S t a t e

1115 Demonstration Waiver Request for the Primary Care Network of Utah

Utah Department of Health
Division of Health Care Financing
November 15, 2001

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I. Environment

1.1 CURRENT STATUS OF HEALTH INSURANCE IN UTAH

The best information on health insurance coverage in Utah comes from the 1996 Utah Health Status Survey (UHSS). Somewhat more recent information on coverage rates can be obtained from the Current Population Survey (CPS) conducted by the U.S. Census Bureau. Unfortunately, CPS and UHSS data do not agree and are not comparable. For that reason, the CPS estimates are used only for judging trends in the coverage rates. The CPS consistently provides higher estimates of the percentage of uninsured. Several differences between CPS and the UHSS exist, but the reason that seems most likely to explain the difference in estimates is that the CPS has been shown to underestimate coverage by Medicare and Medicaid programs.

Another source of state-specific rates of health insurance coverage that is available that provides more recent data is the Behavioral Risk Factor surveillance System (BRFSS), a state-based survey coordinated by the Centers for Disease Control and Prevention. The BRFSS assesses insurance status only among adults (age 18 years or over). The BRFSS survey also provides estimates of the percentage of uninsured in Utah that are not comparable to those provided by the UHSS, but may be useful in judging trends. From 1996 to 1999, the percentage (of adults) uninsured estimated by the BRFSS did not change. From 1996 to 1998, the percentage without health insurance estimated by the CPS increased from 12.0 percent to 13.9 percent (a statistically significant increase of 2 percent). (Campbell JA, Health Insurance Coverage: 1998. Current Population Reports. U.S. Census Bureau, October 1999.) As stated, the CPS data are used only for trend analysis, as the CPS estimates are statistically imprecise for smaller

states such as Utah.

1.1.01 Percentage of Utahns Without Health Insurance

In 1996, the Utah Health Status Survey[1] estimated that 9.5 percent of the Utah population was without any kind of health insurance. The UHSS showed no

change in coverage rates between 1991 and 1996. If the percentage of Utahns without health insurance remained constant from 1996 to 2000, there would be 205,000 Utahns without health insurance in 2000. The UHSS will be repeated in 2001.

Based on the 1996 UHSS, sub-populations with higher percentages of people without health insurance were:

a. Young adults age 18-34 years old (15 percent without health insurance).
b. Adults without a high school education (26 percent).
c. Persons in households with incomes less than $15,000 a year (24 percent).
d. Unemployed adults (19 percent).

[1]The 1996 Utah Health Status Survey estimates were based on a telephone survey of approximately 6,300 Utah households. Health insurance was assessed for each member of those households (approximately 20,700 individuals).

e. Persons of Hispanic ethnicity (21 percent).[2]
f. Persons living outside the more urban Wasatch Front (12 percent).
g. Residents of several more rural health districts (e.g., Tri-county and Southwest Utah Health Districts, 17 and 16 percent, respectively).
h. Persons who reported fair or poor health status (12 percent).

1.1.02 Characteristics of Those Without Health Insurance

Seventy-two percent (72 percent) of Utahns without insurance resided on the Wasatch Front, which contains approximately 77 percent of the population of the state, with males representing 53 percent of the uninsured to the 47 percent for females. The 18-34 age group represented the largest group of Utah's uninsured at 43 percent; followed by those under 18 at 29 percent; age group 35-49, at 20 percent; age group 50-64, at 7 percent; and lastly, those over 64 representing 1 percent of the uninsured in the state. Table 1 displays uninsured data for gender and age.

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Table 1.1: Uninsured by Gender and Age

	Percent Who Are Uninsured	Distribution of Uninsured
Female		

[2]Data were insufficient to estimate insurance coverage for racial and ethnic minorities.

	Percent Who Are Uninsured	Distribution of Uninsured
Under 18	8.5%	14.1%
18-34	13.0%	18.7%
35-49	9.6%	10.2%
50-64	6.4%	3.6%
Over 64	0.7%	0.4%
Total Female	8.9%	47.0%
Male		
Under 18	8.7%	15.3%
18-34	16.8%	23.8%
35-49	9.3%	9.9%
50-64	5.7%	3.1%
Over 64	1.9%	0.8%
Total Male	10.2%	52.9%
TOTAL	9.5%	99.9%

The 1996 UHSS also looked at annual household income and discovered that those earning between $25,000 and $35,000 annually represented the largest group in Utah's uninsured population. Table 2 portrays Utah's uninsured by annual household income.

Table 1.2: Uninsured by Annual Household Income

Annual Household Income	Percent Who Are Uninsured	Distribution of Uninsured
Under $15,000	23.9%	17%
$15,000 - $25,000	17.4%	23%
$25,000 - $35,000	15.5%	27%

$35,000 - $45,000	7.1%	14%
$45,000 - $55,000	5.4%	8%
Over $55,000	3.7%	11%
TOTAL	9.53%	100%

Individuals with less than a high school degree represented 16 percent of those Utahns uninsured; high school graduates with some college represented 65 percent; individuals with technical or a vocational degree, 5 percent; and finally, those with college and graduate degrees represented 14 percent. These data are displayed in Table 3.

Table 1.3: Uninsured by Level of Education

L Ed	Perce U	Dist U
Less than High School		
H.S./Some College		
Tech/Voc Degree		
4 yr. + College Degree		
TOTAL		

Fifty-five percent of Utahns without insurance were employed full time; 18 percent were employed part time; 3 percent were retired; 12 percent were homemakers; 3 percent were students; and 8 percent were unemployed or "other." These data are given in Table 4.

Table 1.4: Uninsured by Employment Status

Em	Perce U	Dist U
Employed, Full Time		
Employed, Part Time		
Retired		
Homemaker		
Student (Primary Status)		
Unemployed/Other		
TOTAL		

Although risk groups could be defined above in which health insurance coverage rates were lower than for Utahns overall, in many ways those without health insurance looked quite similar to Utah's population. Those without health insurance were predominantly:

a. high school graduates (84 percent of uninsured adults, compared with 94 percent of surveyed adults);
b. Wasatch Front residents (72 percent of uninsured, compared with 77 percent of the population).
c. full-time employees (55 percent of uninsured adults, compared with 56 percent of all surveyed adults);
d. individuals living in households with incomes below $35,000 (67 percent of the uninsured); and
e. children and young adults age 34 or under (72 percent of uninsured adults, compared with 60 percent of the Utah population).

Most Utahns without health insurance reported having been without insurance for substantial lengths of time. Only 25 percent had been without insurance for six months or less, 11 percent for six months to one year, and the remainder for at least one year. Over half had been without insurance for more than two years, and 37 percent for four or more years.

1.1.03 Reasons for Not Having Health Insurance

The most common reasons reported for not having health insurance were "Can't afford it" (41 percent of households where at least one member was without insurance), and "Employer doesn't offer" (16 percent). Fourteen percent cited pre-existing conditions, denials, or other reasons that made them "uninsurable" and 9 percent reported that lack of employment prevented them from obtaining insurance. A common concern expressed by policy-makers was that "can't afford it" could represent a decision to allocate sufficient financial resources to other purposes. Although that is a difficult issue to completely resolve, the survey results suggested that most of those who reported they couldn't afford health insurance really couldn't afford it. Of those who cited "can't afford it" as the reason for being without health insurance, 55 percent reported annual household incomes below 200 percent of the federal poverty level, 83 percent were below 300 percent of the poverty level, and 81 percent reported their household savings were less than two months' income.

Additional data on health insurance among children are available from a recent Child Health Survey.[3] As with adults, the most common reasons for lack of health insurance for children were inability to afford the premiums (58 percent), employer not offering health insurance (34

[3]The data reported here are all preliminary unpublished data from a telephone survey conducted 11/99 to 1/00 that included 2,536 Utah households.

percent), and a recent loss of or change of jobs (28 percent). In this survey, respondents could cite more than one reason. Only 21 percent reported the child's good health was the reason they were not insured.

1.1.04 Employment and Health Insurance

Most of the uninsured lived in a household where the head of that household was employed at least part time (82 percent). Among households without health insurance where the head of the household was employed:

a. 29 percent of those heads of household were self-employed.
b. 46 percent of those heads of household worked for companies with 20 or fewer employees.
c. 42 percent of those heads of household had been working for their current employer for less than one year, but 28 percent had been working for their current employer for five or more years.

1.1.05 Consequences of Lack of Health Insurance

Utahns without health insurance were five times as likely to report they had had problems gaining access to necessary medical, dental or mental health care in the past year (10 percent without vs. 2 percent with).

In 14 percent of all Utah households surveyed, the respondent reported that a household member had been prevented from changing jobs for reasons related to health insurance coverage.

1.2 EFFORTS TO REDUCE THE NUMBER OF UNINSURED IN UTAH

1.2.01 Health Reform Efforts Before 1993

Utah has a long history of collaborative efforts to improve access to health care for its indigent and uninsured populations. In the period before 1993, such efforts were limited to safety net initiatives, with two notable exceptions:

In 1986 the Robert Wood Johnson Foundation funded the Utah Small Employer Health Plan (USEHP), a project planned by a public/private partnership of Utah's top leaders in public and private health care. The USEHP Project was an affordable, comprehensive health care coverage plan for primary as well as acute inpatient care and prescription drugs offered at an affordable price to small employers. It was discontinued primarily because of poor enrollment, an issue that has continued to haunt several health care coverage initiatives.

The Health Care Access Steering Committee, created in 1987, was a large voluntary public-private initiative that spent nearly four years examining the health care system in Utah. The result was a set of strategies that set the stage for future health reform in the state.

1.2.02 Significant Safety Net Initiatives Prior to1993

a. The establishment of the Utah Medical Assistance Program (UMAP) in 1977. UMAP provides care for acute and life-threatening conditions to single adults without children who do not qualify for Medicaid.
b. The Caring Program for Children was founded in 1992 by Regence Blue Cross-Blue Shield of Utah. It relied on charitable donations to provide health care coverage for children ineligible for publicly funded programs or unable to afford private insurance.

1.2.03 Health Reform Efforts After 1993

The first significant state executive effort to expand access to health coverage took the form of Governor Leavitt's *HealthPrint*, drafted in 1993 in response to the recommendations of the Health Care Policy Options Commission.

As the Governor's master plan for reforming health care in Utah, *HealthPrint* initiated a seven-year process for expanding access to and improving the quality of health care for all Utahns. Central to the accomplishment of *HealthPrint*'s goals was the creation of the Utah Health Policy Commission (HPC). The HPC was chaired by the Governor and Lieutenant Governor and had 12 members: six at-large members appointed by the Governor; three senators, including at least one from the minority party; and three members of the House of Representatives.

Through the formation of twelve Technical Advisory Groups (TAGs), the HPC pursued the goals of *HealthPrint* by developing policy alternatives and recommending legislative reform in areas of access, quality and cost. Many of the reform strategies outlined in *HealthPrint* required legislation. Over the course of its tenure as the entity responsible for overseeing and developing *HealthPrint*'s central access provisions, the HPC recommended and supported the passage of thirty four (34) pieces of legislation:

a. March, 1994. Health Care Reform I. Creates the Health Policy Commission and defines its duties.
b. July, 1994. Health Care Reform II. Children ages 12-17 who live in households at or below 100% of the FPL become eligible for Medicaid.
c. July, 1994. Coverage of all unmarried dependents up to age 26 must be provided under any individual or group insurance policy.
d. July, 1994. Insurers must offer, as well as quote, a designated benefit plan.

e. January, 1995. Renewal of coverage guaranteed for small employers except for certain stated conditions, such as nonpayment of premium, etc.
f. January, 1995. Rating bands established requiring insurers to charge health insurance premiums within set rates for new businesses and a two-year phase-in period for existing business allowed.
g. January, 1995. Pre-existing conditions are limited to a one-year period for small groups, changing their insurance plans. For existing businesses, exclusion riders must come off on the renewal anniversary date.
h. January, 1995. Policies that were in force within 90 days of the effective date of new coverage must give full credit for pre-existing conditions waiting periods accumulated under previous coverage.
i. July, 1995. Persons who have incomes below the FPL and who are elderly or disabled become eligible for Medicaid.
j. July, 1995. Submission of an 1115 Waiver, Medicaid may provide for eligibility for all persons who have incomes below the FPL.[4]
k. January, 1995. Health Systems Improvement Act. Medical savings accounts become effective retroactively for taxable years beginning on or after January 1, 1995.
l. July, 1995. Variances may be granted to remote-rural acute care hospitals for specific services currently required for licensure under general hospital standards established by Department rule.
m. July, 1995. Area Health Education Centers programs established and funded.
n. July, 1995. Health quality initiative encounter level data elements established and funded.

[4]The waiver was not approved by HCFA for reasons based on cost-neutrality.

o. January, 1996. All individual policies are afforded the same protections as small group policies: portability, rating bands, preexisting conditions limitations, and renewability.
p. January, 1996. Limited open enrollment provisions for small groups sized 2 to 50.
q. January, 1996. Basic benefit plan becomes effective under limited open enrollment.
r. January, 1996. Medical Savings Account Amendments. Amends the Medical Savings Accounts to include penalties for noncompliance with tax requirements.
s. April, 1996. Health Care Quality. Authorizes the Health Data Committee to publish reports comparing and identifying health care providers.
t. April, 1996. Medicaid Transition Funding. Creates a Medicaid Restricted Account that directs all unexpended general funds appropriated to Health Care Financing be lapsed into the account at the end of each fiscal year to expand medical assistance coverage.
u. July, 1996. Voluntary Health Insurance Purchasing Alliance Act. Allows the creation of voluntary health insurance purchasing alliances.
v. January, 1997. Medical Savings Account Amendments. Eliminates double deduction of federal and state taxes on Medical Savings Accounts.
w. May, 1997. Provisions for individuals and one-person groups become subject to limited open enrollment.
x. July, 1997. Medical Education Program. Authorizes the creation of Medical Education Council to secure federal funding for graduate medical education, to allocate the distribution of funds, and to determine the needs of health care professionals.
y. July, 1997. Rural Health Care Providers Amendments. Requires an HMO to pay for medical services rendered to an

enrollee by an independent health center located in a county with a population density of less than 100 persons per square mile and within 30 miles of the enrollee.

z. July, 1997. Open Enrollment Amendments. Modifies the eligibility requirements and premium rates for comprehensive health pool; authorizes the issuance of certificates of individuals whose health conditions do not meet insurance pool criteria; requires individual carriers to cover individuals who present a certificate from insurance pool.

aa. July, 1998. Children's Health Insurance Program (CHIP).

bb. July, 1999. Long Term Care Amendments. Allows state tax deduction for premiums for long term care insurance.

cc. July, 1999. Office of Consumer Health Assistance. To assist citizens with health insurance information, education, and advocacy.

dd. July, 2000. Grievance Review Process. Permits an insuree to challenge an adverse health insurance decision through an internal review process and by an independent review process.

ee. July, 2000. Medical Exclusions in Individual Health Insurance Policies. Allows an insurer and insured to agree to exclude a specific health condition. An excluded conditions is an uncovered pre-existing condition.

ff. July, 2000. Utah Telehealth Act. Establishes the Utah Telehealth Commission and duties and responsibilities.

gg. July, 2000. Health Insurers-Coverage of Emergency Medical Services. Establishes a prudent layperson standard.

hh. July, 2000. Health Insurers-Referral to Specialist Process. Requires an insurer to establish a process for standing referrals to specialists.

1.2.04 Creation of Utah's CHIP Program

Perhaps no effort to expand coverage saw as much effective cooperation between executive, legislative, Health Policy Commission, Department of Health, and private sector decision makers as the implementation of Utah's CHIP Program in 1998. Utah is one of ten states that chose not to expand Medicaid but to create a new state program administered by the Department of Health.

So far, the CHIP program has an enrollment of over 26,000 children out of an estimated 30,000. The statewide Covering Kids project, a coalition of public and private sector decision makers and advocates for the low-income uninsured, was successful in its application for a Robert Wood Johnson Foundation grant for two pilot projects to expand access to CHIP through school and community-based outreach programs. These efforts are showing positive results, already serving as models to other health-related outreach efforts.

1.2.05 Primary Care Grants Program (PCGP)

Established in 1996, the state's PCGP has successfully targeted Utah's low-income families who are without health insurance or who have health insurance that does not cover primary health care services and who cannot qualify for Medicare, Medicaid, or CHIP. The goal of the PCGP is to provide a "medical home" to all eligible medically under served populations: "continuous, high quality, cost-effective primary health care services." The intent of the PCGP is also to increase the organizational capacity of grantees (primary care provider organizations like community health centers) so that the awarded projects are able to serve more eligible individuals (Annual Report of the State Primary Care Grants Program, 1999). Supported in its first three years through the Legislature's Mineral Lease Fund, the program will soon complete its fourth contracting cycle. Since these discretionary monies were appropriated to other programs by statute, the 2000 legislature decided to fund the program using the Medicaid Restricted

Account, the account established in *HealthPrint* to expand coverage to the uninsured. The 2001 legislature then moved the appropriation to an on-going general fund appropriation.

1.2.06 Ongoing Health Care Safety Net Efforts

There are numerous collaborative projects throughout the state that act as a safety net for the uninsured and under-insured. These include:

a. Community Health Centers (CHC): Provide quality primary care services to individuals who have inadequate or no access to health care through ten different programs located at twenty-two different sites throughout Utah. This program is notable as it serves minorities who are disproportionately represented among the low-income uninsured.

b. Intermountain Health Care Clinics: Lincoln Family Health Center is a school-based family clinic funded by IHC—Utah's largest non-profit health plan—serving seven schools and their families. IHC also runs the Sorenson Clinic which provides primary care services to those in an underserved area of Salt Lake City.

c. Utah Medical Assistance Program (UMAP) is a state-funded medical assistance program for low-income individuals with serious medical problems who are ineligible for Medicaid and Medicare.

d. University of Utah Hospital and Clinics: Provides $30 million of un-compensated charity care to the indigent and uninsured on an inpatient and outpatient basis.

e. Dental Services: Provided by CHCs, DHCF fixed and mobile

clinics, Primary Children's Hospital, University of Utah Dental Clinic, and two volunteer agencies, Donated Dental and Dental House Calls.

1.2.07 The Future of Health Care Reform in Utah

With current resources becoming stretched, and with the continuing inflation in health care costs, Utah's health care safety net is fast becoming unsustainable. These same pressures have also brought the issue of the uninsured to the forefront of public and private, academic and mainstream, rural and urban policy discussions in Utah. Among key players and decision makers in all arenas, a consensus is emerging to reduce health and access disparities.

Utah recently received the HRSA State Planning Grant which will take up where the Health Policy Commission left off. The partnership formed under this planning grant will be designed to build on the strengths, and learn from the limitations of previous efforts. With an uninsured rate of approximately 9.5%, the state of Utah has a compelling opportunity to create one of the lowest uninsured rates in the U.S.A.

1.3 UTAH'S FREEDOM-OF-CHOICE WAIVERS

Utah has two managed care programs operating under two different freedom-of-choice waivers which both have the goal of managing care, providing quality care, controlling costs, and increasing accessibility for Medicaid clients by linking clients to providers. The two programs are called the Choice of Health Care Delivery Program and the Prepaid Mental Health Plan. The Division of Health Care Financing, Utah's Medicaid agency, in the Department of Health administers both waivers.

1.3.01 Choice of Health Care Delivery Program

Utah's Choice of Health Care Delivery program was implemented in March 1982. Since October 1, 1995, Utah's Medicaid agency has been operating under a modification to the waiver that requires Medicaid clients living in Utah's urban counties (Weber, Davis, Salt Lake and Utah) to select a managed care organization (MCO). Utah is operating this waiver program under the authority of Section 1915(b)(1), (2) and (4) of the Social Security Act. Since July 1, 1996 approximately 94 - 96% of Medicaid urban clients have been enrolled in MCOs.

Currently, the Medicaid agency contracts with four MCOs: American Family Care (AFC), Healthy U, IHC Access and United/MedChoice. All MCOs are options in all four urban counties except United/MedChoice which is not available in Utah county. All but Healthy U are licensed as HMOs by the Department of Insurance. Healthy U meets the qualifications of a state plan-defined health plan. The Medicaid agency enters into risk-comprehensive contracts with all MCOs.

Enrollment in an MCO is mandatory for all Medicaid eligibles living in urban counties except those residing in long-term care facilities or clients in state institutions (State Hospital or State Development Center), those with an eligibility period that is less than three months, those with an eligibility period that is only retroactive or for those months that their eligibility is retroactive or those approved through a request to be exempt from mandatory enrollment. Enrollment in an MCO is an option in the southwestern and northern parts of the state.

Health program representatives employed by the Medicaid agency serve as enrollment brokers as well as health care advocates for Medicaid clients. Every new applicant for Medicaid in the urban counties is offered an orientation about Medicaid and the Choice of Health Care Delivery Program. Medicaid clients who do not select an MCO are assigned to one of the MCOs available in the client's county. Clients may switch MCOs at any time for any reason; however, the request to change must be made by the 20th of the month in order for the client to be enrolled

with the new MCO the following month.

All Medicaid services in the Utah State Plan are covered by the MCOs except mental health, substance abuse (other than inpatient detoxification), chiropractic, non-emergency transportation, dental, pharmacy, early intervention, and home/community based services of 1915(c) services.

1.3.02 Prepaid Mental Health Plan

On July 1, 1991, the Utah Prepaid Mental Health Plan (PMHP) was implemented in three areas of the state. Utah is operating this waiver program under the authority of Section 1915(b)(1) and (4) of the Social Security Act which provides for restriction of Medicaid eligible to specified providers. Under this provision, Medicaid clients living in certain Utah counties must obtain mental health services from PMHPs that have contracts with the Medicaid agency. The PMHP contractors are either governmental or quasi-governmental agencies. Effective January 1, 2002 the waiver will be in all but one of Utah's 29 counties; eight of the ten community mental health centers have contracts under this waiver.

The original purpose of the PMHP was to control Medicaid expenditures for inpatient psychiatric care by promoting psychiatric care in the most appropriate and cost-effective setting, including alternatives to inpatient hospital care. Another purpose was to promote access through a coordinated state and local mental health delivery system that provides access to an appropriate array and mix of service for all Medicaid recipients in need of such services. The ultimate goal is to improve treatment outcomes and satisfaction with mental health services.

The Utah Medicaid program provides a comprehensive array of mental health services. The PMHP contractors are required to provide all outpatient mental health services covered in the Utah State Plan, inpatient psychiatric and physician-related inpatient services.

A Medicaid client is automatically enrolled in the PMHP if the client lives in one of the counties covered by the waiver and is not in a group excluded from participation. Enrollment in the PMHP is mandatory for all Medicaid eligibility groups except residents of the Utah State Hospital, Utah State Developmental Center, and those who live in counties excluded from the waiver. In addition, effective July 1, 1995, foster care children have been excluded from the waiver for outpatient mental health services. Approximately 98% of Medicaid eligibles are enrolled in the PMHP.

1.3.03 Fee-for-Service and Primary Care Case Management

In areas where enrollment in an MCO is not mandated, recipients have a choice of fee-for-service or enrolling with a primary care physician. In two areas of the state, there is also the option of enrollment in an MCO. Applicants for Medicaid in these rural areas of the state are provided education and selection information either by the local health department or in some areas the health program representative that established eligibility for Medicaid.

1.4 ADVOCATE INPUT

The department has a multi-varied approach to alerting the public and receiving the advise and recommendations from affected advocacy groups and individuals. There are several on-going forums where the proposal will be discussed, including, but not limited to the following.

1.4.01 The Utah Medical Care Advisory Committee (MCAC).

Utah's Medicaid program has an active, involved advisory committee. The MCAC has been given a briefing on the proposal and will be updated on a regular basis. Some members have already expressed interest in being involved in the development and review of the waiver.

The MCAC meetings draw community advocates and provider representatives to the monthly meetings, and members are expected to pass important issues back to their constituencies. Therefore, the MCAC will be one effective way to provide public notice and obtain comments back on the 1115 proposal.

1.4.02 Utah Issues Meetings.

Utah Issues is a local advocacy group for low income issues. It coordinates monthly meetings between the department and members of Utah's advocacy community. The 1115 proposal has been discussed briefly with this group and will become an on-going agenda item.

1.4.03 The Utah Indian Health Advisory Board.

The department meets monthly with tribal representatives. The 1115 proposal will be discussed with the board early in the process to provide notice and begin the dialogue with the tribes of Utah.

1.4.05 The Ethnic Health Board.

The department meets monthly with representatives from different ethnic populations of Utah. The 1115 proposal will be presented and discussed with this committee early on in the process to provide notice and begin the dialogue with the ethnic minority populations of the state.

1.4.06 Utah Medical Assistance Program (UMAP) Coalition.

Because of changes that have been made in Utah's medical program for non-categorical adults, a coalition of community providers, government agencies and advocates has been created. The 1115 proposal will be discussed in this forum to provide notice and receive comment as the proposal develops.

1.4.07 HRSA Planning Grant.

Utah has received a $1.1 million grant from HRSA to collect data and develop plans to address the challenge of the uninsured in Utah. The planning process will involve widespread representation from all sectors of Utah that have an interest in the uninsured issue. This will include interested private citizens, providers, agencies, advocacy groups, small and large business, and academia. The 1115 proposal will be one of the proposals that gets broad discussion as part of this year-long process.

1.4.08 The Legislative Task Force.

The Utah Legislature has created a task force that will be looking at the issue of access to health care. The task force will be composed of legislators and the Executive Director of the Department of Health and the Insurance Commissioner. The task force will be kept apprised of the development of the 1115 waiver proposal. This will be one vehicle to insure Utah legislators and others are informed about the changes contemplated in the Medicaid program.

1.5 STATE LEGISLATION

The department has been given broad discretion to administer the Medicaid program. While state legislation is not required to apply for or implement this 1115 proposal, the department will work closely with the legislature before implementing an approved 1115 waiver request.

1.6 STATE BUDGET

The expansion being proposed equates to approximately 3% of all program expenditures. Due to the modest nature of this expansion and the concept of an enrollment cap should expenditures begin to exceed the budget, we anticipate no problems in sustaining adequate financing for the life of the waiver.

II. Administration

The Utah Department of Health is the single state agency responsible for the administration of the Utah's Medicaid Program. The Medicaid program is both a federal and state-funded program that provides statewide medical coverage to Utah residents who meet certain poverty and categorical eligibility requirements. Additionally, Utah has maintained a state-funded program covering those who do not meet Medicaid categorical requirements but have very low incomes. This program is also administered by the Utah Department of Health.

Beginning in January 1, 1994, in line with the Utah Health Care Reform Initiative, eligibility for medical services was transferred from the Utah Department of Human Services (DHS) to the Utah Department of Health (DOH). The resulting effect creates a class of eligibility workers who are expert in Medicaid, SCHIP and community health programs. Out-stationed eligibility workers are assigned to take applications for medical services in hospitals, community health centers, local health departments, some area agencies on aging and other community sites. The division also provides all eligibility services for Utah's SCHIP program. DHCF now has staff located in approximately 90 different sites across the state. TANF cases are administered by the Utah Department of Workforce Services (DWS).

Medicaid covered over 222,000 Medicaid eligibles during state fiscal year 2000 at a cost of over 795 million dollars. Over 10,000 medical providers within the state provided care to Medicaid recipients during this same period. These providers also offer primary and preventative care, as well as specialty care. In addition to basic required Medicaid services, Utah offers 26 optional services managed by the Division of Health Care Financing.

2.1 CURRENT DEPARTMENTAL ORGANIZATIONAL STRUCTURE

2.1.01 Departmental Composition.

The Utah Department of Health is comprised of different divisions and offices responsible for overseeing public health and health system issues in the state. Some of the major organizational units of the department are: (An organizational chart of the department is provided in Attachment A, page 104.)

a. Division of Community and Family Health Services

b. Division of Health Care Financing

c. Division of Health Systems Improvement

d. Division of Epidemiology and Laboratory Services

e. Office of Public Health Assessment

f. Office of the State Medical Examiner

g. Children's Health Insurance Program

2.2 DIVISIONAL ORGANIZATIONAL STRUCTURE

2.2.01 Divisional Composition.

The Division of Health Care Financing administers the state Medicaid program under the rules and regulations of Title XIX of the Social Security Act and is responsible for the Medicaid program planning and policy development, contract administration, and quality assurance functions. The division will administer the 1115 waiver demonstration program. The division is organized in nine branches: five bureaus, one office, and three units, as follows. (Organizational charts of the division and bureaus are provided in Attachment A, page 104.)

a. Office of the Director. The Office of the Director is responsible for administering and coordinating the program responsibilities delegated to staff in order to develop Utah's Medicaid program in compliance with Title XIX of the Social Security Act, the laws of the state of Utah, and the appropriated budget.

b. Bureau of Coverage, Reimbursement Policy and Utilization Management. This bureau makes recommendations to the division director dealing with scope of services and payment methodologies for services, with special emphasis on negotiating actuarially sound capitation rates. Further, the bureau is responsible for the utilization management of the Utah Medicaid program.

c. Bureau of Eligibility Services. Eligibility Services is responsible for determining the Medicaid eligibility policies and field operations related to the determination of Medicaid eligibility.

   The Bureau of Eligibility Services is responsible for coordinating and overseeing the eligibility contract with the Department of Workforce Services (TANF Agency) and providing coordinating with the Office of Recovery Services IV-D Agency.

d. Bureau of Financial Services. Financial Services provides four main functions within the division:

   1) Manages the administration and service budgets for both the Medicaid and UMAP programs.

   2) Monitors the drug rebate program within the state.

   3) Performs audits on Medicaid providers within the state to cost settle Medicaid rates reimbursements and performs cost studies on reimbursement rates to evaluate if fair rates are being set for provider services.

4) Evaluates hospital and nursing home bed patient days and regulates tax assessments for these services.

e. Bureau of Managed Health Care. Managed Health Care is the operational arm of the Freedom of Choice Waivers and has responsibility for the implementation and operation of the managed care initiates that includes contracting with health maintenance organizations (HMOs) and Prepaid Mental Health Plans (community mental health centers) to serve the medical and mental health needs of Medicaid clients. Also, the bureau is responsible for the development and operation of Medicaid specialized services for special populations, the operation of children's HCBS waivers and the school based services program.

f. Bureau of Medicaid Claims Processing. This bureau ensures that:

1) Providers are informed and trained in Medicaid policy and procedures.

2) Claims are paid accurately and timely.

3) Supporting computer data bases, i.e., MMIS, are current and accurate.

g. Information Technology Unit. The Information Technology Unit is responsible for the development, operation and maintenance of the Medicaid Management Information System (MMIS). The unit also provides support for information analysis needs of the division as well as other data processing needs.

h. Long Term Care Unit. The Long Term Care Unit is responsible for policy development in the area of both institutional and community based service programs. The unit also provides contract support and oversight of home and community based service waivers

where the daily administration has been delegated to the Department of Human Services.

i. Research and Analysis Unit. The Research and Analysis Unit is located in the Office of the Director and provides program research, evaluation and analysis support. The Medicaid Eligibility Quality Control and the CPAS and SPR are housed within this unit.

2.3 PROPOSED ADMINISTRATIVE STRUCTURE OF THE 1115 DEMONSTRATION

2.3.01 Policy Determination.

The Utah Division of Health Care Financing will determine eligibility policy for participation in Utah's Medicaid Program and be responsible for maintaining data and evaluation of the demonstration project.

2.3.02 Eligibility and Enrollees.

The Bureau of Eligibility Services will be responsible for educating individuals whose eligibility is established at out-station sites for the demonstration project and addressing enrollee problems. Questions from the clients related to eligibility will continue to be handled by the unit.

The number of people choosing to participate in the 1115 waiver group will affect the number of eligibility workers needed; however, streamlining the eligibility process may significantly reduce the number of new workers necessary to process the new demonstration groups.

2.3.03 Negotiating and Monitoring Provider Network.

The Bureau of Managed Health Care will be responsible for ensuring the adequacy of the provider network. The bureau will ensure that all eligibles are enrolled with a primary care provider and will be responsible for negotiating, executing and monitoring any contracts necessary to accomplish this task. Monitoring functions include:

a. Quality assurance.

b. Grievance and problem resolution.

c. Financial solvency.

d. Client and provider satisfaction.

2.3.04 Project Data Collection, Evaluation and Reporting.

Research and Evaluation will be responsible for ensuring all required data for evaluating the results of Utah's demonstration project are obtained and are accurate. The state must collect and track demonstration data through the end of the project to show that the waiver program is performing as desired. This unit is located in the Office of the Director and will design and administer survey instruments for evaluating recipient access and utilization.

a. The Office of Public Health Assessment will provide additional assistance to the division in the essential analysis of data for the evaluation portion of the waiver project.

III. Eligibility

The effort to cover up to 41,000 new Medicaid recipients will utilize simplified eligibility determination and application procedures. This group is composed of adults age 19 to 64 who are not currently eligible for Medicaid. The result will be eligibility requirements easier to understand, and less burdensome for the clients. Spenddown will not be an option for this group. Also, policy will be developed to insure those eligible for other Medicaid Categories do not default into this category. This program is intended to be the Medicaid program of last resort.

3.1 CURRENT ELIGIBILITY CATEGORIES

Utah currently has the following categories of eligibility for Medicaid services available under its State Plan:

3.1.01 Family Medical (FM)

This Medicaid category covers single parents, disabled parents and/or under-employed parents with dependent children. Family Medical is for families who receive TANF cash assistance or who do not want TANF cash assistance or who have incomes too high to qualify for TANF cash assistance. Non-cash families must generally meet all of the eligibility criteria for the old AFDC program with the exception of income and assets.

Income Limits:	$382	1 Person in Household
	$468	2 Persons
	$583	3 Persons
	$682	4 Persons
Asset Limits:	$2,000	1 Person
	$3,000	2 Persons

Add $25 for each additional person.

Spend down:Allowed.

Retroactive Coverage:Allowed

3.1.02. Transitional Medicaid (TM)

Families who become ineligible for Medicaid assistance due to increased earnings or child support payments may still receive the FM (Medicaid only) coverage during a "transition" period. The transition period allowed is two years.

Income Limits:Only earned income is countable. Family gets first 6 months regardless of income. Family earned income must be at or below 185% of the federal poverty limit to continue eligibility for the second 6 months.

Asset Limits: None

Spend down:Not allowed.

Retroactive Coverage:Not allowed.

3.1.03 Medically Needy Child (MNC)

Families not meeting AFDC rules (children are not deprived of support) may still receive a Medicaid card for the children. A "child" is anyone under age eighteen, or someone expected to graduate from secondary school or training by age nineteen.

Income Limits: $382 1 Person in Household
$4682 Persons
$5833 Persons
$6824 Persons

Asset Limits: $2,0001 Person
$3,0002 Persons

Add $25 for each additional person.

Spend down:Allowed.

Retroactive Coverage:Allowed

3.1.04 Prenatal Program (PN)

This is a program under Section 1902(1)(1)(A) of the Act which allows prenatal care for poverty-related pregnant women. The program covers the mother from the month of application to 60 days after the birth; women only have to qualify for one month to be eligible for the entire period. Children born to women on this program may qualify for Medicaid through age one under the Postnatal program. Prenatal income is calculated at 133% of poverty.

Income Limit: $953 1 Person in Household
$1,2872 Persons
$1,6223 Persons
$1,9574 Persons

Asset Limits: Household assets must be less than $5,000. Households that have assets exceeding the $5,000 limit must spend down four percent of the total asset amount up to a maximum of $3,367.

Spend down:Not allowed on income.

Retroactive Coverage: Allowed.

3.1.05 Pregnant Women (PG)

A Medicaid program for pregnant women which is rarely used since the

Prenatal program began. The advantage for this program is that women who do not meet the income limits for the Prenatal Program may pay a spend down on this program and receive the coverage. The income and asset limits for this program are the same as the Family Medical program. The women must be eligible for a category of Medicaid to qualify for this program. However, deprivation of parental support is not required. The client may receive sixty days of Medicaid coverage after the termination of the pregnancy provided application is made before the pregnancy terminates. The child will qualify for Medicaid for the first year under the Postnatal program.

3.1.06 Postnatal (PN+)

Coverage is available under Section 1902(1)(1)(B) of the Act for children from the month of birth through the month in which the child turns age one. The child's mother must have been covered under a Utah Medicaid program for the month the child was born.

Income Limits:None.

Asset Limits: None.

Spend down:Not allowed.

Retroactive Coverage: Allowed.

3.1.07 Newborn Medicaid (NB)

Medicaid coverage for poverty-related children through the month in which the child turns age 6 is made available under the State Plan under Section 1902(1)(1)(A)(C) of the Act. Income limits calculated on 133% of poverty.

Income Limits: $953 1 Person in Household
$1,2872 Persons
$1,6223 Persons
$1,9574 Persons

Asset Limits:None.

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.08 Newborn Plus Medicaid (NB+)

Medicaid coverage for children age six and older through the month in which the child turns age 19. Income is calculated on 100% of poverty.

Income Limits: $716 1 Person in Household
$968 2 Persons
$1,2203 Persons
$1,4714 Persons

Asset Limits: $2,0001 Person
$3,0002 Persons

Add $25 for each additional person.

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.09 TANF Cash, IV-E Foster Care (FC) and SSI Cash Recipient (SA) Medicaid

Foster Care Medicaid is provided to children who are placed in state custody. Subsidized Adoption Medicaid is provided to children who have ben adopted through a subsidized adoption program.

3.1.10 Utah Medical Assistance Program (UMAP)

A state sponsored program for adults between ages 18 and 65 who need medical attention but do not qualify for Medicaid or Medicare. The resource limits are low compared to other programs. The services are also very limited.

Income Limits: $337 1 Person in Household
$413 2 Persons
$516 3 persons
$602 4 Persons

Asset Limit: $500 1 Person
$750 2 or More People

Spend down:Up to $50 is allowed.

Retroactive Coverage:One month only.

3.1.11 Emergency Medical Assistance (EMA)

Emergency medical treatment is available for certain aliens who are

ineligible for Medicaid because they do not meet the U.S. citizenship requirements for Medicaid. This program pays for emergency services only. Citizenship and Social Security number requirements are waived for this program. To qualify for this program, a person must meet the eligibility requirements under a current Medicaid program.

3.1.12 Poverty Level Aged and Disabled

Provides Medicaid to seniors and disabled individuals whose income is below 100% of poverty.

Income Limits: $716 1 Person in Household
$968 2 Persons
$1,2203 Persons
$1,4714 Persons

Asset Limits: $2,0001 Person
$3,0002 Persons

Add $25 for each additional person.

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.13 Aged, Blind, Disabled Medical (AB&D)

Provides a Medicaid card for individuals who are aged (65+), blind, or disabled. People who want to qualify on the basis of blindness or disability must have a physical or mental impairment which can be expected to result in death or to last for not less than 12 months; be of such severity the person is unable to do his or her previous work; and, the person cannot, considering his or her age, education, and work

experience, engage in any other kind of substantial gainful work. Receipt of SSI or SSA disability automatically meets the conditions for disability. If the person receives SSI, there is no spend down to receive the Medicaid coverage. The SSI person's income doesn't count for the Medicaid card unless the person is institutionalized or approved for a Home and Community Based Waiver.

NOTE: The various "protected groups" such as those covered under the Pickle Amendment, Adult Disabled Children, etc., are covered but not described here.

Income Limits: $382 1 Person in Household
$468 2 Persons
$583 3 Persons
$682 4 Persons

Asset Limits: $2,0001 Person
$3,0002 persons

Add $25 for each additional person.

Spend down:Allowed.

Retroactive Coverage: Allowed.

3.1.14 Nursing Home (NH)

Pays for nursing home or medical institutional costs and other medical costs.

Income Limits:Complicated. Short term stays (less than 6 month s) are different than long term stays.

Deductions:Complicated. Spouse at home is allowed

to keep a portion of total income for living expenses. $45 for personal needs is allowed for the institutionalized client.

Asset Limits: Complicated. The nursing home client is allowed $2,000. The spouse at home is allowed a portion of the assets the couple joint ly owned when the client entered the nursing home. Clients can be denied nursing home Medicaid coverage for a period of time for transferring away assets for less than fair market value.

Spend down:Allowed.

Retroactive Coverage: Allowed.

3.1.15 Home and Community Based Waivers for DD/MR, Seniors, Brain Injured, Technology Dependent Children, and Physically Disabled

HCBS programs help severely disabled people and seniors remain in their home rather than being institutionalized. The number of individuals served is limited. Parent's income and assets are not counted toward a minor child's eligibility; an intensive service plan is drawn up for the client; and all services are paid for by Medicaid.

Income Limits:100% of poverty.

Asset Limits:Same as NH Medicaid. Clients can be denied waiver Medicaid coverage for a period of time for transferring away assets for less than fair market value.

Spend down:Allowed.

Retroactive Coverage:Allowed.

3.1.16 Optional TB Eligibility

Provides outpatient services for individuals infected with tuberculosis. Services are designed for completion of TB therapy and include targeted case management services, directly observed therapy, physician, clinic, lab, x-ray.

Income Limits:$1,053 per month.

Asset Limits:$2,000

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.17 Qualified Medicare Beneficiaries Program (QMB)

This program does not issue a Medicaid card, but pays for patient cost-sharing charges on Medicare services for low-income Medicare recipients. People who receive or are eligible to receive Part A Medicare may apply for QMB. QMB pays Medicare Part A and B premiums and deductibles, 20% co-payment of Medicare approved amounts, and co-payment for Medicare approved skilled nursing home.

Income Limits: 100% of Poverty.

Asset Limits: $4,0001 Person in Household
$6,0002 Persons

Spend down:Not allowed.

Retroactive Coverage:Not allowed. Coverage begins the month after the eligibility decision is made.

3.1.18 Specified Low-Income Medicare Beneficiaries (SLIMB) and Qualified Individuals

This program pays for the client's Part B Medicare premium. Part B of Medicare covers a person's physician care and out-patient treatments. The income limits are calculated on 135% of poverty. The only benefit on this program is the payment of the Part B premium.

Income Limits: 100% of poverty.

Asset Limits: $4,0001 Person in Household
$6,0002 Persons

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.19 Qualified Individuals II

Minimal benefit program.

Income Limits: 175% of poverty.

3.1.20 Workers with Disabilities (effective 7/1/01)

This program covers individuals who continue to meet disability criteria and are employed. There is a premium requirement of 20% of net

income.

Income Limits:250% of poverty.

Asset Limits:$15,000

Spend down:Not allowed.

Retroactive Coverage:Allowed.

3.1.21 Breast and Cervical Cancer Treatment (effective 7/1/01)

This program covers individuals who have a positive screening through the CDC program and are uninsured.

Income Limits:250% of poverty.

Asset Limits:None.

Spend down:Not allowed.

3.1.22 Children's Health Insurance Program (CHIP)

This program is a non-Medicaid program for children under 19. It covers uninsured children under age 19 with a benefit package similar to that offered under the public employees plan. The eligible child cannot be Medicaid eligible.

Income Limits:200% of poverty.

Asset Limits:None.

Spend down:Not allowed.

3.2 PROPOSED 1115 WAIVER ELIGIBILITY CATEGORIES

3.2.01 Traditional Medicaid[5]

Title XIX clients eligible for the traditional Medicaid program will continue to receive all of the full benefits and services detailed in the Medicaid State Plan. Coverage will continue to provide these services to:

a. disabled;
b. aged;
c. children; and
d. pregnant women.

A complete description of benefits and services, exclusions and co-payment requirements are listed under section 4.1.

3.2.02 PEHP-Based Plan[6]

This plan represents a reduced benefit plan for some mandatory and optional groups that previously received full benefits under the Medicaid State Plan. Those eligible for benefits and services under this plan include:

a. TANF adults;
b. transitional Medicaid adults; and

[5]Referred to as Plan C in previous draft documents.

[6]Referred to as Plan A in previous draft documents.

c. medically needy adults.

A full description of the benefits received under this plan is contained under Section 4.2, with exclusions and co-payments listed under sections 4.4 and 4.5, respectively. An annual enrollment fee of $50 will be collected.

3.2.03 Primary Care Network[7]

Benefits under this 1115 waiver project, *the Primary Care Network,* of basic primary care benefits, a reduced slate from those received under the traditional Medicaid program and the PEHP-based program. Eligibles under this program will include:

a. those not eligible under Title XIX; and
b. adults up to 200% of the FPL guidelines.

A full description of the benefits received under this plan is contained under section 4.3, with exclusions and co-payments listed under sections 4.4 and 4.6, respectively.

3.3 PROPOSED ELIGIBILITY STANDARDS FOR PCN ELIGIBLES

3.3.01 Income

Gross Income limits will be up to 200% of the federal poverty guidelines (FPL). There will be no income disregards to evaluate. Income will be evaluated at time of application, and upon an annual redetermination interview over the phone or through the mail, whenever possible, using a simple questionnaire. Income determination will be based on an annualized calculation using the rules and procedures implemented

[7]Referred to as Plan B in previous draft documents.

under the state's Children's Health Insurance Program (CHIP).

3.3.02 Assets

There will be no asset test of an applicants's resources.

3.3.03 Spend Down

An individual whose gross income exceeds 200% of FPL will not be allowed to spend down income in this program. Spend down will continue for those categorically eligible for the traditional Medicaid program.

3.3.04 Insurance Availability

An individual who has access to other health insurance coverage must apply for and enroll in that coverage.

3.3.05 Crowd Out

A prospective client is **not** eligible for Primary Care Network (PCN) program enrollment if he or she **voluntarily** terminates coverage of any health insurance plan within six months of applying for the PCN program. A client may be eligible beginning the 182nd day after the prior insurance coverage ended.

A prospective client who is **involuntarily** terminated from a group health insurance plan is eligible for the PCN program. The 6 month ineligibility period does not apply when the termination is involuntary. For example: if an employer terminates group health insurance coverage for all employees or a prospective client has been terminated from a job or quits a job and that results in loss of health insurance coverage. A prospective client is not required to purchase any available COBRA health insurance coverage.

3.3.06 Citizenship

Citizenship, residency and Social Security Number policy will follow current Medicaid policies.

3.3.07 Categorical Requirements

An individual who meets the categorical requirements for Medicaid will not be eligible.

3.3.08 Application

There will be a $50 application fee at the time of application and upon annual redetermination.

3.4 WAIVER IMPACT

3.4.01 Positive Impact

The proposed 1115 waiver demonstration program will provide Medicaid coverage for a significant cohort of currently uncovered adults, including most current UMAP eligibles. As a condition of eligibility, those who have access to health care insurance must apply for that coverage.

Additionally, eligibility spans will be longer, allowing more continuity of care and certainty of eligibility.

Finally, the eligibility process will be simpler and more easily accessed.

3.4.02 Negative Impact

There will be some negative impact. Those eligible for UMAP as a result of receiving General Assistance will no longer be automatically eligible for

this coverage.

Currently those that have access to other health care coverage are disqualified, or are required to apply for those benefits as a condition for Medicaid eligibility. Under this coverage that will be an eligibility requirement.

Lastly, this category of coverage will not have a spend down provision. If an applicant/recipient has gross income in excess of 200% of the FPL, they will not be eligible.

3.5 ELIGIBILITY DETERMINATION, ENROLLMENT AND CLIENT EDUCATION

3.5.01 Eligibility Determination

a. Program eligibility sites will be available statewide and eligibility will be determined by DHCF eligibility workers. The DHCF will continue to work with FQHCs, local health departments, local hospitals and other community sites to ensure on-site processing of applications. It is the intention of the DHCF to enhance the ability of out-stationed, high-volume Medicaid providers to expand on-site application processing.

b. After the date of implementation (between March, 2002 and July, 2002), new program eligibles will be entered into the demonstration program on the date of their application.

c. Eligibility determination will occur using a simple form asking for information from the applicant concerning the limited income, citizenship, age, name, address, social security number, and other criteria listed above.

d. Benefits will be available from the date of the application. There

will be no retroactive eligibility. Applications can be obtained at a number of offices in the community and around the state (see list below). These applications can be filled out and mailed in by applicants, and the date of eligibility will be the postmark on the envelope.

e. Upon favorable determination of eligibility and payment of the annual fee ($50) clients will receive an ID card annually that will entitle them to benefits.

3.5.02 Eligibility Periods

Once determined eligible, the client will retain eligibility for a period of twelve months. The eligibility period will change only if:

a. the client moves out of state, or dies;
b. becomes eligible under another Medicaid category;
c. the source of income changes; and
d. other reasons for cause.

3.5.03 Client Enrollment

Health Program Representatives (HPRs) of the DHCF will be responsible for explaining the program options to eligible clients and for enrolling and disenrolling clients with primary care physicians. Enrollment and disenrollment will occur over the phone, in person, or through the mail.

When possible, the clients will have a face-to-face meeting with the HPR at the time of the eligibility determination for Medicaid coverage. The HPR will provide the clients with general information about Medicaid coverage and network access points.

3.5.04 Client Education

The state will develop a program to disseminate statewide information

about the new programs and how it differs from traditional Medicaid coverage. Printed program materials will be translated into languages other than English, when appropriate, and will be distributed during face-to-face encounters whenever possible. The state will mail information to interested parties when a face-to-face encounter is not possible. Formal program education will be a continuing responsibility of the HPR during the enrollment processes.

In addition, the state will enlist the efforts of other state agencies and groups, such as the Office of Vocational Rehabilitation, in an informal instructional effort to give present and future Medicaid-eligible, PEHP-based, and PCN individuals timely and pertinent program information. Program information will include all information germane to the eligibility, enrollment and selection processes, where and when eligibility can be determined, and combined with other information felt by the state to be applicable. Such educational materials will be distributed and made available by, among others:

a. The Division of Health Care Financing
b. All other appropriate divisions and program in the State Department of Health
c. All divisions and programs of the State Department of Work Force Services
d. Office of Vocational Rehabilitation
e. Other state, local and community agencies
f. Employment offices
g. Local health departments
h. Essential community service providers
i. Schools and churches
j. Social Security offices
k. Appropriate meetings and conferences
l. Community health centers
m. Homeless health centers

The state will retain final approval, through the Bureau of Eligibility Services and the Bureau of Managed Health Care, of all educational materials used in both the formal and informal educational processes. The state will review the completed outreach plan with CMS prior to full scale implementation.

Prior to enrollment, when possible, clients will view a videotape explaining the waiver program, and other important program details, such as, emergency room use. They will receive a brochure reinforcing this information. The recipient will be given a list of the qualifying provider serving the area of the waiver demonstration program. The printed informational materials will be translated into languages other than English, as necessary. A toll-free number will be established to respond to any questions the clients may have in reference to the program.

3.5.05 Administrative Considerations

a. There will be an enrollment cap. The goal is to enroll up to 41,000 adults. However, if expenses exceed revenues at any point, the Department of Health reserves the right to freeze enrollment for part or all of the remaining fiscal year.

b. The waiver program will receive comprehensive IT support from the Department of Health, including the Financial Assistance Management Information System (FAMIS).

IV. Coverage and Benefits

4.1 TRADITIONAL MEDICAID PROGRAM PLAN[8]

Covered Services: The traditional Medicaid health plan will provide the following benefits to enrollees in accordance with Medicaid benefits as defined in the Utah State Plan subject to the exception or limitations as noted below. The Medicaid agency reserves the right to interpret what is in the state plan. Medicaid services can only be limited through utilization criteria based on medical necessity.

A contracting health plan will provide at least the following benefits to enrollees. The health plan is responsible to provide or arrange for all medically necessary covered services on an emergency basis 24 hours each day, seven days a week. This plan is responsible for payment for all covered emergency services furnished by providers that do not have arrangements with the plan.

4.1.01 Hospital Services

a. Inpatient hospital

Services furnished in a licensed, certified hospital.

b. Outpatient hospital

Services provided to enrollees at a licensed, certified hospital who are not admitted to the hospital.

c. Emergency department services

[8]This plan has been referred to as Plan C in previous draft iterations.

Emergency services provided to enrollees in designated hospital emergency departments.

4.1.02 Physician Services

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision.

4.1.03 General Preventive Services

This health plan must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional groups such as the American Academy of Pediatric and the U.S. Task Force on Preventive Care.

A minimum of three screening programs for prevention or early intervention (e.g. pap smear, diabetes, hypertension).

4.1.04 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, and opticians within their scope of practice. Eyeglasses will be provided to eligible recipients based on medical necessity. Services include, but are not limited to, the following:

a. Eye refractions, examinations
b. Laboratory work
c. Lenses
d. Eyeglass frames

e. Repair of frames
f. Repair or replacement of lenses
g. Contact lenses (when medically necessary)

4.1.05 Lab and Radiology Services

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites, including physician office labs, providing services under this contract will have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of Waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

4.1.06 Physical and Occupational Therapy

a. Physical therapy

Treatment and services provided by a licensed physical therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to an enrollee by or under the direction of a qualified physical therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 rule.

b. Occupational therapy

Treatment and services provided by a licensed occupational therapist. Treatment and services must be authorized by a physician and include services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided to an enrollee by or under the direction of a qualified occupational therapist. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.1.12 rule.

4.1.07 Speech and Hearing Services

Services and appliances, including hearing aids and hearing aid batteries, provided by a licensed medical professional to test and treat speech defects and hearing loss.

4.1.08 Podiatry Services

Services provided by a licensed podiatrist.

4.1.09 End Stage Renal Disease - Dialysis

Treatment of end stage renal dialysis for kidney failure. Dialysis is to be rendered by a Medicare-certified dialysis facility.

4.1.10 Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses, licensed practical nurses, and home health aides) in the client's home when the client is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified home health agency that has a surety bond.

Personal care services as defined in the Medicaid Agency's Medicaid Personal Care Provider Manual are included in this contract. Personal care services may be provided by a state licensed home health agency.

4.1.11Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

4.1.12Private Duty Nursing

Services provided by licensed nurses for ventilator-dependent children and technology-dependent adults in their home in lieu of hospitalization if medically necessary, feasible, and safe to be provided in the patient's home. Requests for continuous care will be evaluated on a case by case basis and must be approved by this health plan.

4.1.13Medical Supplies and Medical Equipment

The covered services includes any necessary supplies and equipment used to assist the enrollee's medical recovery, including both durable and non-durable medical supplies and equipment, and prosthetic devices. The objective of the medical supplies program is to provide supplies for maximum reduction of physical disability and restore the enrollee to his or her best functional level. Medical supplies may include any necessary supplies and equipment recommended by a physical or occupational therapist, but should be ordered by a physician. Durable medical equipment includes, but is not limited to, prosthetic devices and specialized wheelchairs. Durable medical equipment and supplies must be provided by a durable medical equipment supplier that has a

surety bond. Necessary supplies and equipment will be reviewed for medical necessity and follow the criteria of the R414.12 of the Utah Administrative Code, with the exception of criteria concerning long term care since long term care services are not covered under the contract.

4.1.14 Abortions and Sterilizations

These services are provided to the extent permitted by Federal and state law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. These requirements must be met regardless of whether Medicaid is primary or secondary payer.

4.1.15 Treatment for Substance Abuse and Dependency

Treatment will cover medical detoxification for alcohol or substance abuse conditions. Medical services including hospital services will be provided for the medical non-psychiatric aspects of the conditions of alcohol/drug abuse.

4.1.16 Organ Transplants

The following transplantations are covered for all enrollees: Kidney, liver, cornea, bone marrow, heart, intestine, lung, pancreas, small bowel, combination heart/lung, combination intestine/liver, combination kidney/pancreas, combination liver/kidney, mult-visceral, and combination liver/small bowel.

4.1.17 Other Outside Medical Services

This health plan, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, surgical centers and birthing centers.

4.1.18 Long Term Care

This health plan may provide long term care for enrollees in skilled nursing facilities requiring such care as a continuum of a medical plan when the plan includes a prognosis of recovery and discharge within thirty (30) days or less. When the prognosis of an enrollee indicates that long term care (over 30 days) will be required, this health plan will notify the Medicaid agency and the skilled nursing facility of the prognosis determination and will initiate disenrollment to be effective on the first day of the month following the prognosis determination. Skilled nursing care is to be rendered in a skilled nursing facility which meets federal regulations of participation.

4.1.19 Transportation Services

This health plan may provide ambulance (ground and air) service for medical emergencies. This health plan is also responsible to pay for authorized emergency transportation for an illness or accident episode which, upon subsequent medical evaluation at the hospital, is determined to be psychiatric-related. This health plan will submit its emergency transportation policy to the Medicaid agency for review. This health plan is not responsible for transporting an enrollee from an acute care facility to another acute care facility for a psychiatric admission. This health plan's scope of coverage for emergency transportation services is limited to the same scope of coverage as defined in the transportation Medicaid provider manual.

4.1.20 Services to CHEC Enrollees

a. <u>CHEC Services</u>

This health plan will provide to CHEC enrollees preventive screening services and other necessary medical care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan. This health plan is not responsible for home and community-based services available through Utah's Home and Community-Based waiver programs.

This health plan will provide the full early and periodic screening, diagnosis, and treatment services to all eligible children and young adults up to age 21 in accordance with the periodicity schedule as described in the Utah CHEC Provider Manual. All children between six months and 72 months must be screened for blood lead levels.

b. CHEC policies and procedures

This health plan agrees to have written policies and procedures for conducting tracking, follow-up, and outreach to ensure compliance with the CHEC periodicity schedules. These policies and procedures will emphasize outreach and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHEC enrollees.

4.1.21 Family Planning Services

These services include disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services must be provided in concert with Utah

law.

Birth control services include information and instructions related to the following:

a. Birth control pills
b. Norplant;
c. Depo Provera;
d. IUDs;
e. Barrier methods including diaphragms, male and female condoms, and cervical caps;
f. Vasectomy or tubal ligations; and
g. Office calls, examinations or counseling related to contraceptive devices.

4.1.22 High-Risk Prenatal Services

a. <u>In General - ensure services are appropriate and coordinated</u>

This health plan must ensure that high risk pregnant enrollees receive an appropriate level of quality perinatal care that is coordinated, comprehensive and continuous either by direct service or referral to an appropriate provider or facility. In the determination of the provider and facility to which a high risk prenatal enrollee will be referred, care must be taken to ensure that the provider and facility both have the appropriate training, expertise and capability to deliver the care needed by the enrollee and her fetus/infant. Although many complications in perinatal health cannot be anticipated, most can be identified early in pregnancy. Ideally, preconceptional counseling and planned pregnancy are the best ways to assure successfull pregnancy outcome, but this is often not possible. Provision of routine preconceptional counseling must be made

available to those women who have conditions identified as impacting pregnancy outcome, i.e., diabetes mellitus, medications which may result in fetal anomalies or poor pregnancy outcome, or previous severe anomalous fetus/infant, among others.

b. Risk assessment criteria

Enrollees who are pregnant should be risk assessed for medical and psychosocial conditions which may contribute to a poor birth outcome at their first prenatal visit, preferably in the first trimester. The patient who is determined not to be at high risk should be evaluated for change in risk status throughout her pregnancy. There are a number of complex systems to determine how to assess the risk of pregnancies. The Medicaid agency has developed a risk assessment tool available through the Division of Community and Family Health Services which is available upon request.

c. Recommended prenatal screening

The Medicaid agency recommends prenatal screening of every woman for hepatitis B surface antigen (HbsAg) to identify those at high risk for transmitting the virus to their newborns. When a woman is found to be HbsAg-positive, this health plan will provide HBIG and HB vaccine at birth. Initial treatments should be given during the first 12 hours of life.

d. Classification

Upon identification of pregnancy or the development of a risk factor, each patient should be assigned a classification as outlined below.

1. *Group I.* Group I patients have no significant risk factors. They may receive obstetrical care by an obstetrician/gynecologist, family practitioner or certified nurse midwife.

2. *Group II.* Group II patients have the following risk factors and require consultation (consultation may be either by telephone or in person, as appropriate) with an OB-GYN:

   i) pregnancy beyond 42 weeks
   ii) pre-term labor in the current pregnancy less than 34 weeks
   iii) fetal malpresentation at 37 weeks gestation and beyond*
   iv) oxytocin or antepartum prostaglandin use is contemplated*
   v) arrest of dilation in labor, or arrest of descent in labor*
   vi) bleeding in labor, beyond bloody show*
   vii) abnormal fetal heart rate pattern potentially requiring specific intervention*
   viii) chorio-amnionitis*
   ix) pre-eclampsia
   x) VBAC*

   *Criteria do not apply if family physician has cesarean privileges.

3. *Group III.* Group III patients have the following risk factors and require consultation by a Maternal Fetal Medicine (MFM) specialist (board certified perinato-

logist)

i) intrauterine growth restriction prior to 37 weeks.
ii) patient at increased risk for fetal anomaly (including teratogen exposure)
iii) patient has known fetal anomaly
iv) pre-term delivery (^36 weeks) in a prior pregnancy
v) abnormal serum screening
vi) previous child with congenital anomaly
vii) antibody sensitization
viii) anemia, excluding iron deficiency
ix) significant concurrent medical illness
x) spontaneous premature rupture of the membranes, not in labor (^34 weeks)
xi) history of thrombo-embolic disease
xii) thrombo-embolic disease in current pregnancy
xiii) habitual pregnancy loss (3 or more consecutive losses)
xiv) two or more previous stillbirths or neonatal deaths

4. *Group IV*. Group IV patients have the following risk factors and require total obstetric care by an OB/GYN, or co-management with an OB/GYN or MFM

i) any significant medical complication, including patients with insulin dependent diabetes mellitus, chronic hypertension requiring medication, maternal neoplastic disease
ii) twins
iii) known or suspected cervical incompetence
iv) placenta previa beyond 28 week gestation
v) severe pre-eclampsia

5. *Group V.* Group V patients have the following risk factors and require total obstetric care by a MFM (exceptions may be made by a regional MFM specialist, on a case-by-case basis, after MFM consultation)

   i) triplets and above
   ii) patient has an organ transplant (except cornea)
   iii) diabetes mellitus with severe renal impairment
   iv) cardiac disease, not functional class I, including al pulmonary hypertension
   v) twin-twin transfusion syndrome
   vi) patient requires fetal surgical procedure

4.1.23 Prenatal Initiative Program

Prenatal services provided directly or through agreements with appropriate providers includes those services covered under Medicaid's Prenatal Initiative Program which includes the following enhanced services for pregnant women:

a. perinatal care coordination
b. prenatal and postnatal home visits
c. group prenatal and postnatal education
d. nutritional assessment and counseling
e. prenatal and postnatal psychosocial counseling

Psychosocial counseling is a service designed to benefit the pregnant client by helping her cope with the stress that may accompany her pregnancy. Enabling her to manage this stress improves the likelihood that she will have a healthy pregnancy. The counseling is intended to be short term and directly related to the pregnancy. However, pregnant women who are also suffering from a serious emotional or

mental illness should be referred to an appropriate mental health care provider.

4.1.24 Services for Children with Special Needs

a. In general.

This health plan agrees to cover all medically necessary services for children with special health care needs such as the ones listed below. This health plan further agrees to cooperate with the Medicaid agency's quality assurance monitoring for this population by providing requested information.

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all areas of need to be most effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

b. Services requiring timely access

All children with special health care needs must have timely access to the following services:

i) Comprehensive evaluation for the condition.
ii) Pediatric sub-specialty consultation and care appropriate to the condition.
iii) Rehabilitative services provided by professionals

with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

iv) Durable medical equipment appropriate for the condition.

v) Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

c. Definition of children with special health care needs

The definition of children with special health needs includes, but is not limited to, the following conditions:

i) Nervous System Defects such as:

- Spina Bifida*
- Sacral Agenesis*
- Hydrocephalus

ii) Craniofacial Defects such as:

- Cleft Lip and Palate*
- Treacher - Collins Syndrome

iii) Complex Skeletal Defects such as:

- Arthrogryposis*
- Osteogenesis Imperfecta*
- Phocomelia*

iv) Inborn Metabolic Disorders such as:

- Phenylketonuria*

- Galactosemia*

v) Neuromotor Disabilities such as:

- Cerebral palsy*
- Muscular Dystrophy*
- Complex Seizure Disorders

vi) Congenital Heart Defects

vii) Genetic Disorders such as:

- Chromosome Disorders
- Genetic Disorders

viii) Chronic Illnesses such as:

- Cystic Fibrosis
- Hemophilia
- Rheumatoid Arthritis
- Broncho-pulmonary Dysplasia
- Cancer
- Diabetes
- Nephritis
- Immune Disorders

ix) Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

In addition, children with the conditions marked by an asterisk (*) above have timely access to

coordinated multi-specialty clinics for their disorder, when medically necessary.

4.1.25 Medical and Surgical Services of a Dentist

a. Who may provide services

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery. Such services are covered under the Medicaid contracts with managed care organizations

b. Universe of covered services

Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under the contract.

c. Services specifically covered

Palliative care and pain relief for severe mouth or tooth pain in an emergency room are covered services. This health plan is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease including, but not limited to removal of tumors in the mouth, setting and wiring a fractured jaw. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital this health plan is responsible for coverage of the inpatient hospital stay.

d. Dental services not covered

This health plan, when administered by a managed care organization under contract with the agency, is not responsible for services that are usually considered dental such as fillings, pulling of teeth, treatment of abscess or infection, orthodontics, and pain relief when provided by a dentist in the office or in an outpatient setting such as surgical center or scheduled same day surgery in a hospital. (See 4.1.28)

4.1.26 Diabetes Education

This health plan shall provide diabetes self-management education from a Utah certified or American Diabetes Association recognized program when an enrollee:

a. has recently been diagnosed with diabetes, or

b. Is determined by the health care professional to have experienced a significant change in symptoms, progression of the disease or health condition that warrants changes in the enrollee's self-management plan, or

c. is determined by the health care professional to require re-education or refresher training.

4.1.27 HIV Prevention

a. General program

This health plan must have educational methods for promoting HIV prevention to enrollees. HIV prevention information, both primary (targeted to uninfected enrollees), as well as secondary

(targeted to those enrollees with HIV) should be culturally and linguistically appropriate. All enrollees should be informed of the availability of both in-plan HIV counseling and testing services, as well as those available from Utah state-operated programs.

b. Focused program for women

Special attention should be paid identifying HIV+ women and engaging them in routine care in order to promote treatment including, but not limited to, anti-retro-viral therapy during pregnancy.

4.1.28 Services Not Covered by the Health Plan (Carve-Outs).

The following are services that are provided by Medicaid on a FFS basis and are carve-outs from the health plan (HMO) contracts in force in the urban areas of the state. These services are provided to Medicaid clients in accordance with the benefits as defined in the Utah State Plan.

a. Pharmacy
b. Dental
c. Mental health
d. Substance abuse
e. Home and community based waiver service
f. Targeted case management
g. Chiropractic
h. Long term care

4.2 CO-PAYMENT REQUIREMENTS FOR TRADITIONAL MEDICAID CLIENTS

Co-pays are not applicable to pregnant women, children, institutionalized recipients and emergency services.

4.2.01 Pharmacy

$1.00 per prescription with a limit of five co-pays per month.
$2.00 per doctor's visit.
$2.00 per outpatient hospital visit.

4.2.02 Hospital

$6.00 per visit to emergency department for non-emergency care when provided under the FFS program. Not applicable under the agency managed care contracts

$2.00 co-pay on physician, podiatrist and out-patient hospital services. This co-pay is applicable under the FFS and managed care programs, and is also
applicable to services obtained from FQHCs, and local health departments and clinics.

4.3 PEHP PLAN FOR SECTION 1931 ELIGIBLES AND MEDICALLY NEEDY[9]

Covered Services: The following benefits, limitations, exclusions, and co-pay requirements will cover section 1931 eligibles and medically needy adults.

The health plan shall provide the following benefits to enrollees subject to the exclusions or limitations noted under *PEHP and PCN Exclusions* (at 4.5) below. The health plan shall provide at least the following benefits to its enrollees.

The health plan is responsible to provide or arrange for all appropriate covered services on an emergency basis 24 hours each day, seven days a week. The health plan is responsible for payment for all covered emergency services furnished by providers that do not have arrangements with this health plan.

4.3.01 Hospital Services

a. Inpatient Hospital

Services furnished in a licensed, certified hospital.

b. Outpatient Hospital

Services provided to enrollees at a licensed, certified hospital who are not admitted to the hospital.

c. Emergency Department Services

Emergency services provided to enrollees in designated hospital emergency departments.

4.3.02Physician Services

Services provided directly by licensed physicians or osteopaths, or by

[9]This plan has been referred to as Plan A in previous draft iterations.

other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

4.3.03Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Services include:

a. Eye refractions, examinations.

b. One exam every 12 months.

4.3.04 Lab and Radiology Services

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this contract must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

4.3.05 Physical Therapy/Chiropractic

Treatment and services provided by a licensed physical therapist or chiropractor. Treatment and services for physical therapy must be authorized by a physician. Coverage includes up to 16 visits per policy year. This benefit may include occupational therapy for fine motor function.

4.3.06 Hearing Services

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss. One exam every 12 months. Hearing aids are covered only to improve an impairment due to a congenital defect.

4.3.07 Podiatry Services

Services provided by a licensed podiatrist.

4.3.08 End Stage Renal Disease - Dialysis

Treatment of end stage renal failure by dialysis. Dialysis is to be rendered by a Medicare-certified dialysis facility.

4.3.09 Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses and licensed practical nurses) in the client's home when the client is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified Home Health Agency.

4.3.10 Speech Therapy

Services provided by a licensed speech language pathologist if therapy is to restore speech loss or to correct impairment if due to a congenital defect or an injury or sickness.

4.3.11Hospice Services

Service delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care. Hospice care is to be rendered by a Medicare-certified hospice.

4.3.12 Abortions and Sterilizations

These services are provided to the extent permitted by Federal and state law and must meet the documentation requirement of 42 CFR 44, Subparts E and F. Abortion services to unmarried minors must have written notification of the parent or legal guardian.

4.3.13Organ Transplants

The following transplantations are covered for all enrollees: kidney, liver, cornea, bone marrow, stem cell, heart and lung, unless amended under the provisions of this health plan contract.

4.3.14 Other Outside Medical Services

This health plan, at its discretion and without compromising quality of care, may choose to provide services in freestanding emergency centers, surgical centers and birthing centers.

4.3.15 Transportation Services

Ambulance (ground and air) service for medical emergencies.

4.3.16Preventive Services and Health Education

This health plan shall provide to enrollees preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

4.3.17 Family Planning Services

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be

provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services provided must include prior written consent of a minor's parent or legal guardian. All services must be provided in concert with Utah law.

The following family planning services are **not** covered:

a. Norplant
b. infertility drugs
c. in-vitro fertilization
d. genetic counseling

4.3.18 Pharmacy Services

Prescribed drugs and preparations provided in a licensed pharmacy, Over the counter (OTC) drugs are not covered. An approved list of covered name brand drugs may be established by the department advisory board of medical professionals.

4.3.19 Mental Health

a.. Inpatient care (Residential treatment may be provided in lieu of inpatient care.)

30-day maximum for inpatient/residential care per year.

i) If an enrollee would be otherwise hospitalized for treatment of a mental illness or substance abuse, and In lieu of hospitalization, a lower level of care can be used; then

ii) the lower level of care may be substituted at a rate of one outpatient visit in lieu of each inpatient day

which would be otherwise required.

b. Outpatient services/visits

30 visits per enrollee per year for outpatient services.

4.3.20 Dental Services

The following dental services based on American Dental Association (ADA) codes are covered:

a. 0120, 0140 and 0150 (exams)
b. 0220, 0230, 0270, 0272 (x-rays)
c. 0274 (bitewing)
d. 1110 (cleaning for age 16 and older)
e. 1120 (cleaning)
f. 1201, 1205 (fluoride with cleaning)
g. 1203 (fluoride without cleaning)
h. 1351 (sealant)
i. 1510 through 1550 (space maintainers)
j. 2110 through 2161 (fillings)
k. 2330, 2331, 2332, 2335 (fillings)
l. 3220, 3230, 3240 (pulpotomy)
m. 7110, 7110 D, 7120, and 7120 D (extractions)

4.3.21 Medical and Surgical Services of a Dentist

Under Utah law, medical and surgical services of a dentist may be provided by either a physician or a doctor of dental medicine or dental surgery. Medical and surgical services that under Utah law may be provided by a physician or a doctor of dental medicine or dental surgery, are covered under this contract under certain conditions including, but not limited to, the following:

a. Services to repair injuries or accidents to sound, natural teeth are covered under the Contract.

b. When an enrollee is treated in an emergency room for severe mouth or tooth pain, the services are covered under this contract. This health plan will reimburse such emergency providers based on standard emergency use criteria or a triage fee per this health plan's provider contracts. If the emergency room physician determines that it is not an emergency and the client requires services at a lesser level, the provider should refer the client to a dentist for treatment. If the dental-related problem is serious enough for the client to be admitted to the hospital this health plan is responsible for coverage of the inpatient hospital stay.

c. This health plan is responsible for authorized/approved medical services provided by oral surgeons consistent with injury, accident, or disease including, but not limited to, removal of tumors in the mouth, setting and wiring a fractured jaw.

4.3.22 Interpretive Services

Services provided by contracting entities competent to provide medical translation services for people with limited English proficiency and interpretive services for the deaf.

4.4 PRIMARY CARE NETWORK PLAN[10]

Covered Services. The plan administrator shall provide the following benefits

[10]This plan has been referred to as Plan B in previous draft iterations.

to enrollees under this plan—enrollees that are not currently Medicaid eligible, with earnings up to 200% of the federal poverty limit, subject to the exclusions or limitations noted under *PEHP and PCN Exclusions* (at 4.5 below).

4.4.01 Physician Services

Services provided directly by licensed physicians or other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's supervision. This includes minor surgery and anesthesia that can be performed in an outpatient setting.

4.4.02 Lab and Radiology Services

Professional and technical laboratory and x-ray services furnished by licensed and certified providers.

4.4.03 Durable Medical Equipment and Supplies

Equipment and appliances used to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment.

4.4.04 Preventive Services

Preventive screening services, including routine physical examinations and immunizations.

4.4.05 Family Planning Services

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided or authorized by a physician, certified nurse midwife, or nurse practitioners. All services must be provided in concert with Utah

Law.

The following family planning services are **not** covered:

a. Norplant
b. infertility drugs
c. in-vitro fertilization
d. genetic counseling

4.4.06 Hospital Services

Emergency services provided to enrollees in designated hospital emergency department.

4.4.07 Pharmacy Services

Prescribed drugs and preparations provided by a licensed pharmacy. Over the counter drugs are not covered. An approved list of covered name brand drugs may be established by the department advisory board of medical professionals.

4.4.08 Dental Services

Services include examination, cleaning, fillings, extractions, treatment of abscesses or infection when provided by a dentist in the office. The following dental services based on American Dental Association (ADA) codes are covered:

a. 0120, 0140 and 0150 (exams)
b. 0220, 0230, 0270, 0272 (x-rays)
c. 0274 (bitewing)
d. 1110 (cleaning for age 16 and older)
e. 1120 (cleaning)
f. 1201, 1205 (fluoride with cleaning)

g. 1203 (fluoride without cleaning)
h. 2110 through 2161 (fillings)
i. 2330, 2331, 2332, 2335 (fillings)
j. 7110, 7110 D, 7120, and 7120 D (extractions)

4.4.09 Hearing Services

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss. One exam every 12 months.

4.4.10 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Services include eye refractions:

a. Eye refractions, examination
b. One exam every 12 months

4.4.11 Transportation Services

Ambulance (ground and air) service for medical emergencies.

4.4.12 Interpretive Services

Services provided by contracting entities competent to provide medical translation services for people with limited English proficiency and interpretive services for the deaf.

4.4.13 Health Education

Educational methods and materials for promoting wellness, disease prevention, and management.

4.5 PEHP AND PCN EXCLUSIONS

4.5.01 Hospital Exclusions for PEHP Enrollees.

The plan for PCN enrollees does not cover inpatient or outpatient hospital services except for emergency services in an emergency department.

a. Hospital charges in conjunction with ineligible surgical procedures or related complications.
b. Charges for treatment programs for enuresis (bed wetting) or enco-presis.
c. Convenience items such as guest trays, cots, and telephone calls.
d. Occupational therapy.
e. Recreational therapy.
f. Whole blood.
g. Autologous (self) blood storage for future use.
h. Hospital charges while on leave-of-absence.
i. Charges incurred as an organ or tissue donor. (Such charges may be paid only if the donor and the donee are **both** Medicaid eligible.)
j. Charges for custodial care.
k. Charges for nutritional counseling.
l. Charges for care, confinement, or services in a transitional living facility, community reintegration program, vocational rehabilitation, or services to re-train self-care or activities of daily living.

4.5.02 Surgery Exclusions

a. Breast reconstruction, augmentation, or implant; except restoration made necessary as a result of cancer surgery performed in the preceding five years.
b. Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of

cosmetic or non-covered breast surgery. (Exception may be made based on medical need, when authorized.)

c. Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications. (Exception may be made based on medical need, when authorized.)
d. Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.
e. Cosmetic surgery.
f. Assisted Reproductive Technologies (ART's) including but not limited to In vitro Fertilization Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use.
g. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.
h. Charges incurred as an organ or tissue donor.
i. Organ or tissue transplant (except cornea, kidney, kidney/pancreas, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).
j. Reversal of sterilization.
k. Trans-sexual operations.
l. Rhytidectomy (excision of wrinkles around the eyes).
m. Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.
n. Complications as a result of other non-covered or ineligible surgery. (Exception may be made based on medical need, when authorized.)
o. Injection of collagen.
p. Lipectomy, abdominoplasty, pannulectomy.
q. Repair of diastasis recti.
r. Non-FDA approved, experimental, or investigational

procedures, drugs, and devices.

s. Pellet implantation.
t. Liposuction.
u. Chemical peel.
v. Charges for the treatment of routine foot care such as weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease, such as, diabetes.
w. Orthodontic treatment or expansion appliance in conjunction with jaw surgery.
x. Chin implant, genioplasty or horizontal symphyseal osteotomy, when such procedures are deemed cosmetic.
y. Unbundling or fragmentation of surgical codes.
z. Injections of sclerosing solution for spider veins.
aa. Rhinoplasty, except as a result of accidental injury in the preceding five years.
bb. Laser assisted uvulopalotoplasty (LAUP).
cc. Additional surgical fees are not eligible when a laser is used.

4.5.03 Anesthesia Exclusions

a. Anesthesia charges in conjunction with ineligible surgery.
b. Anesthesia administered by the primary surgeon.
c. Monitored anesthesia care (standby) except in conjunction with procedure #92982, angioplasty.

4.5.04 Medical Visits Exclusions

a. Eye glasses, and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).

b. Examinations made in connection with a hearing aid.
c. Hormone injections or pellet implants (an allowance up to $300 may be approved for injections when oral medication cannot be used). Office visits in conjunction with hormone injections are not eligible.
d. Charges for weight loss or in conjunction with weight loss programs.
e. Charges for medical hospital visits the same day or following a surgical procedure.
f. Charges for office visits in conjunction with allergy injection.
g. Health screening or services to rule out familial diseases or conditions without manifest symptoms.
h. Genetic counseling and testing except prenatal amniocentesis or chorionic villi sampling for high risk pregnancy.
i. Charges for nutritional counseling or analysis.
j. Charges for any injection when the material used is not identified.
k. Hypnotherapy or biofeedback.
l. Chiropractic or physical therapy primarily for maintenance care.
m. Injectable vitamins or their administration.
n. Experimental, investigational, or unproven medical practices.
o. Vision therapy.
q. Tobacco abuse.
r. Take-home medications from a provider's office.
s. Treatment therapies for developmental delay or child developmental programs.
t. Sublingual antigens.
u. Rolfing or massage therapy.
v. Hair transplants or other treatment for hair loss or restoration.
w. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD, or

myofacial pain.

x. Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
y. Charges for prolotherapy or chelation therapy.
w. Office calls in conjunction with repetitive therapeutic injections.
x. Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.
y. Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
z. Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
aa. Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
bb. Charges for sublingual or colorimetric testing.
cc. Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
dd. Charges for the treatment of routine foot care such as weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease, such as, diabetes.

4.5.05 Lab and X-Ray Exclusions

a. Charges in connection with weight loss programs.
b. Health screening or services to rule out familial diseases or conditions without manifest symptoms are considered

routine and are excluded from coverage.

c. Genetic screening except prenatal amniocentesis or chorionic villi sampling or as described in the Pre-Authorization Section above.
d. Charges incurred as an organ or tissue donor.
e. Charges for sublingual or colorimetric testing.
f. Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.
g. Charges for hair analysis, trace elements, or dental filling toxicity.
h. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluation.
i. Routine drug screening.
j. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
k. Unbundling of lab charges. Most multiple labs can be done in panels.

4.5.06 Ambulance Exclusions

a. Charges for common or private aviation services.
b. Services for the convenience of the patient or family.

4.5.07 Home Health and Hospice Exclusions for the PEHP-Based Plan. *The PCN Plan does not cover Home Health and Hospice Services.*

a. Nursing or aide services which are requested for your convenience or the convenience of your family, (i.e., bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter) which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not payable. This exclusion applies regardless of whether services were

recommended by a provider.

b. Private duty nursing.
c. Home health aide.
d. Custodial care.
e. Respite care.
f. Travel or transportation expenses, escort services, or food services.

4.5.08Mental Health and Substance Abuse Exclusions for the PEHP-Based Plan.

The PCN Plan does not cover mental health and substance abuse services.

a. Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.
b. Charges for mental or emotional conditions without manifest psychiatric disorder or non-specified conditions.
c. Office calls in conjunction with repetitive therapeutic injections.
d. Charges in conjunction with wilderness programs.
e. Inpatient charges for behavior modification, enuresis, or encopresis.
f. Psychological evaluations for legal purposes such as custodial rights, etc.
g. Occupational or recreational therapy.
h. Hospital charges while on leave of absence.

4.5.09Durable Medical Equipment Exclusions

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

a. Routine maintenance and care, cleaning solutions, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.
b. Maintenance, warranty, or service contracts.
c. Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.
d. Home physical therapy kits.
e. Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.
f. Air filtration units, vaporizers, humidifiers.
g. Heating lamps or pads.
h. Charges for a continuous hypothermia machine, cold therapy, or ice packs.
i. Dialysis equipment.
j. Orthotics, arch supports, shoe inserts or wedges, etc.
k. Orthopedic or corrective shoes. (Attachment of a brace or crossbar is eligible).
l. Hearing aids (except as indicated under Covered Services).
m. Adaptive devices used to assist with activities of daily living, vocational or life skills.
n. Communicative equipment or devices, systems, or components.
o. Computerized assistive devices; communicative boards, etc.
p. Breast pumps.
q. Vitamins, minerals, food supplements, special infant formulas, or homeopathic medicine.
r. Blood pressure monitors.
s. Wrist alarms for diabetics.
t. Enuresis alarm systems.
u. Spinal pelvic stabilizers.
v. Orthopedic braces solely for sports activities.
w. More than one breast prosthesis for each affected breast following surgery for breast cancer, unless authorized as medically necessary.

x. More than one lens for each affected eye following corneal transplant surgery, unless authorized as medically necessary.
y. More than two pair of support hose for a medical diagnosis per policy year.
z. Computer systems or components.
aa. Environmental control devices, i.e., light switches, telephones, etc.
bb. Replacement of lost, damaged, or stolen DME or prosthetics.
cc. Eye glasses/contact lenses (except as described in Limitations Section).

4.5.10Pharmacy Exclusions

The fact that a provider may prescribe, order, recommend, or approve a prescription drug ,service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

a. Drugs that are not medically necessary for condition.
b. Charges for the treatment of hair loss or restoration (Rogaine).
c. Experimental or investigational drugs.
d. Anorexiants/diet aids (with the exception of Dexe-drine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age 18).
e. Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.
f. Any drug not FDA approved.
g. Therapeutic devices or appliances.
h. Diagnostic agents.
i. Immunization agents, biological serum, blood, or blood plasma.
j. Prescriptions which an eligible person is entitled to receive from any other governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Compensation or employer's liability laws.

k. Medications taken by you or your dependents while in an institution which operates on its premises a facility for dispensing pharmaceuticals.
l. Any drug used for cosmetic purposes.
m. Drugs used by a second party.
n. Replacement prescriptions resulting from loss, theft or breakage.
o. Delivery or shipping charges.
p. Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof, with the exception of IHS facilities.
q. Vitamins, minerals, food supplements, or homeopathic medicine.
r. Mother's milk or special infant formulas.
s. Anabolic steroids (used for muscle building).
t. Medication prescribed as a result of an industrial (on the job) injury or illness payable under Worker's Compensation or employer's liability laws.

4.5.11 General Exclusions

a. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by this program.
b. Charges for educational material, literature, or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illness such as diabetes.
c. Charges for services primarily for convenience, contentment, or other non-therapeutic purposes.
d. Charges for unproven medical practices or care, treatment, or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
e. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.

f. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
g. Charges which the insured is not, in absence of coverage, legally obligated to pay.
h. Charges for services, treatments, or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
i. Shipping, handling, or finance charges.
j. Charges for medical care rendered by an immediate family member are subject to review and may be determined to be ineligible.
k. Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which, is payable under workman's compensation or employer's liability laws.
l. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
m. Charges for expenses in connection with appointments scheduled and not kept.
n. Charges for telephone calls or consultations that are classified as convenience calls.
o. Charges made for completion or submission of insurance forms.

4.5.12 Dental Exclusions

a. General anesthesia, except when approved with pre-authorization and administered by a dentist or certified anesthetist in connection with eligible oral surgery.
b. Tooth implantation, transplantation, or surgical repositioning of teeth.
c. Nitrous oxide, local anesthesia, or non-intravenous conscious sedation.
d. Plaque control programs, oral hygiene instruction, or nutritional counseling.
e. Appliances or restorations necessary to increase vertical dimension or restore or equilibrate the occlusion; occlusal

analysis or adjustments.

f. Charges for services with respect to congenital malformation, cosmetic surgery, or dentistry for solely cosmetic surgery, or dentistry for solely cosmetic reasons, including but not limited to, bleaching, bonding, veneers, ro crowning of peg laterals.
g. Any procedure to diagnose, correct, or treat temporomandibular joint syndrom (TMJ/TMD), or myofunctional therapy.
h. Recording or charting of jaw movements and chewing functions.
i. Sealants, except when placed on permanent molars of eligible dependents through age 17.
j. Dental implants or crowns/pontics/dentures over implants, except as may be pre-authorized under certain conditions.

4.6 CO-PAYMENT REQUIREMENTS FOR PEHP-BASED ENROLLEES

4.6.01 Hospital Services - Inpatient

$100 co-insurance for each inpatient admission.

4.6.02 Hospital Services - Emergency Department

$6.00 co-payment for a non-emergent emergency department visit.

4.6.03 Outpatient Office Visits.

This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.

$3.00 co-payment per visit
No co-payment for preventive services and immunizations.

4.6.04 Prescription Drugs

$2.00 co-payment per prescription

4.6.05 Vision and Hearing Screening Services

100% average of allowed amount up to $30.
Amount above $30 is a non-covered service.

4.6.06 Out-of-Pocket Maximum

$500 per enrollee/year

4.6.07 Balance Billing

No claim for payment, except for co-payments, will be made by this health plan or Health Plan provider from the enrollee for a service covered under the contract.

This health plan and/or Health Plan provider will not balance bill the enrollee and will consider the reimbursement from this health plan plus co-payments as payment in full.

4.7 CO-PAYMENT REQUIREMENTS FOR PCN ENROLLEES

4.7.01 Hospital Services (emergency department)

$30 co-payment for each emergency department visit.

4.7.02 Outpatient Office Visits. This includes physician and physician-related visits.

$5.00 co-payment per visit.

No co-payment for preventive services and immunizations.

4.7.03 Laboratory and X-Ray Services

For laboratory services under $50: No co-payment or co-insurance
For laboratory services above $50: Co-insurance, 5% of allowed amount

For X-ray services under $100: No co-payment or co-insurance
For X-ray services above $100: Co-insurance, 5% of allowed amount

4.7.04 Prescription Drugs

For generic drugs and brand name drugs on an approved list:

$5.00 co-payment per prescription

For brand name drugs not on an approved list:

Co-insurance, 25% of allowed amount

4.7.05 Durable Medical Equipment and Supplies

Co-insurance, 10% of allowed amount

4.7.06 Dental Services

For dental fillings, extractions, x-rays, bitewing, maintainers, pulpotomy:

Co-insurance, 10% of allowed amount

For cleaning, oral exam, sealant, and fluoride:

No co-payment or co-insurance

4.7.07 Out-of-Pocket Maximum

$1,000 per client/year

4.7.8Balance Billing

No claim for payment, except for co-payments and co-insurance, will be made by the provider from the client for a service covered under the contract.

The provider will not balance bill the client and will consider the reimbursement from the plan administrator plus co-payments and/or co-insurance as payment in full.

V. Delivery System

The current delivery system will remain intact under Utah's proposal. The Primary Care Network will use many of the same primary care providers that currently serve the Medicaid population, but because of the substantial differences in the design of the benefit package and reimbursement system, the delivery system will be differentiated by three sub-parts, with delivery for the PCN plan to be developed or contracted out. While the adult population that will receive a slightly reduced Medicaid benefit (PEHP-Based plan) will remain in the current delivery system, a managed care organization rate adjustment will be made to compensate for the reduced cost of this group.

Implementation of this waiver will sub-divide the delivery system into three parts, each part focusing on one of the three programs of benefits and services offered to Utahns by Utah Medicaid. While not totally dependent on managed care organizations (MCOs), the division will continue to rely heavily on them for the delivery of plan benefits and services.

5.1.01 Traditional Medicaid Program

The benefits and services of the standard Medicaid program operating under the Utah Medicaid State Plan will continue to be provided as they are currently to all Medicaid eligible individuals. As such, they will be:

a. provided in the urban areas of the state—along the Wasatch front (Davis, Salt Lake, Utah and Weber counties)—by the MCOs under contract with the division, namely,

1) Intermountain Health Care (IHC)
2) Family Health Care
3) Healthy U (University of Utah)
4) United Health Care

b. provided in the rural areas of the state, some by MCOs, and some by the primary care case management system (PCCM) and some under the fee-for-service program operated by the division.

5.1.02 PEHP-Based Program

This program based on the state employees benefit package will consist of a reduced—from the Traditional Medicaid program—package of benefits and services, and will to be provided to section 1931 adults and the related medically needy, and the transitional Medicaid adults. The plan will be provided:

a. in the urban areas along the Wasatch Front by MCOs; and
b. in the rural areas,

1) on a fee-for-service basis, administered by PEHP and using the PEHP provider network; or
2) on a fee-for-service basis administered by the division using Medicaid providers under the fee-for-service program.

5.1.03 Primary Care Network

The PCN plan of benefits and services for non-Medicaid eligibles with earnings up to 200% of the federal poverty limit will be provided in both the urban and rural areas of the state by:

a. on a fee-for-service basis, administered by PEHP and using the PEHP provider network; or
b. on a fee-for-service basis administered by the division using Medicaid providers under the fee-for-service program.

5.1.04 Delivery Network Expansion

In expanding coverage for the PCN eligibles, the division will use community clinics, such as, the Utah Medical Assistance Program clinics, Community Health Centers, and any other private or public practitioners willing to participate in the program.

FQHCs will be an integral part of the network. The DHCF will not pay on a cost basis for the expansion population, but it will reimburse FQHCs at the same rate paid to other providers in the network. The DHCF will establish a rate separate from Medicaid which should reflect a fair compensation to all network providers. The DHCF will continue to pay FQHCs at the cost-based prospective rates for the current Medicaid population, including the 1931 and medically needy eligibles.

VI. Access

Being concerned with cost containment, Utah began moving towards the use of managed care organizations for the delivery of benefits several years ago. Actuarial analysis of the cost of our MCO products have shown a savings of 5.5% to 7.5% over fee-for-service. The overall program has stayed within budget, showing a minimal surplus in the last budget year and larger surpluses in the three prior years. The rate of growth, due to inflation and utilization of the base program over the past five years has been approximately 6.5% per year. The division has monitored access closely as more and more eligible clients were being served through MCOs.

Utah has not experienced access problems in either its managed care or fee-for-service systems. The most glaring exception to good access is in the dental health area, a problem experienced by most states. However, even with dental health, access has been improving over the past several years.

6.1.01 Access to Care for the Traditional Medicaid and the PEHP-Based Programs

To assure that access to care is available for clients enrolled in MCOs under the Traditional Medicaid, and the PEHP-Based programs, the state Medicaid agency will make certain that:

a. there will be at least two MCOs available to clients in each of the urban counties;

b. clients will be able to choose any MCOs as long as it is available in the client's county;

c. each Medicaid enrollee will have a choice of health professionals within an MCO, to the extent possible and feasible;

d. most of the physicians who have been providers in the Medicaid fee-for-service program, or in the PEHP-Preferred plan,

participate in at least one MCOs;

e. the same range and number of services that are available in the Medicaid fee-for-service program, or in the PEHP-Preferred plan, will be available for MCO enrollees;

f. distances and travel time for MCO enrollees to obtain services will not substantially change from that of the traditional fee-for-service Medicaid program;

g. MCOs provide case management and health education, in addition to primary care, to its enrollees with the goal of fostering continuity of care and improved provider/patient relationships;

h. preauthorization will be precluded for emergency and family planning services under the waiver;

i. MCOs provide or arrange for coverage 24 hours a day, 7 days a week;

j. clients may request an exemption from mandatory MCO enrollment based (only) on a reasonable expectation that the client's health would suffer if the client were unable to obtain an exemption;

k. MCOs do not refuse a selection or dis-enroll clients, or otherwise discriminate against a clients, on the basis of race, color, nationality, disability, age, sex, or types of illness or condition—except when that illness or condition can be treated better by another provider type; and

l. MCOs provide professional interpretive services whenever needed.

6.1.02 Access to Care for the Fee-For-Service Program

To assure that access to care is available for clients receiving services on a fee-for-service basis, the Medicaid agency will allow clients to choose any provider who is a part of the state-wide coalition of private providers, and who guarantees a level of capacity to meet the needs of this new population. The Medicaid agency will make certain that:

a. there are enough providers to adequately handle the needs of clients and that the providers are geographically accessible to clients in terms of distance and time;

b. primary care physicians give 30-day notification to the Medicaid agency or the PEHP the health plan administrator, as well as to the Medicaid clients who the physician serves, if the physician decides to terminate his/her role as a primary care provider, so that continuity of care can be maintained;

c. primary care physicians deliver preventive care and health education, in addition to primary care, to Medicaid enrollees with the goal of fostering continuity of care and improving provider/patient relationships;

d. preauthorization will be precluded for emergency and family planning services;

e. primary care physicians have the capacity to provide or arrange for coverage 24 hours a day, 7 days a week;

f. providers do not refuse selections or dis-enroll clients, or otherwise discriminate against clients on the basis of race,

color, nationality, disability, age, sex, or types of illness or condition—except when that illness or condition can be better treated by another provider type; and

g. providers furnish professional interpretive services whenever needed.

VII. Quality

Consumers have been highly satisfied with both the MCO and fee-for-service systems as determined through satisfaction surveys. Site reviews have uncovered few problems in care. HEDIS reports do show room for improvement in the MCO products when compared to national averages which include commercial plans.

Access to quality of care under the 1115 demonstration waiver will be assured depending on how the service program is administered, whether it be the traditional Medicaid program, the PEHP-Based program for section 1931 adults and the medically needy, or the Primary Care Network being requested by this waiver.

7.1.01 Assuring Access to Quality Health Care in MCOs

Under both the Traditional Medicaid Program and the PEHP-Based Program, the 1115 demonstration grant will require that clients living in the urban counties of Utah select a managed care organization (MCO) that provides, thorough, ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. The MCO will be responsible for monitoring the health care and utilization of services.

To assure that quality health care is provided by MCOs to clients enrolled in MCOs under the Traditional Medicaid Program and under the PEHP-Based Program, the following actions will be enforced.

a. The state Medicaid agency will require, through contract, that MCOs meet state-specified standards for internal quality assurance programs (QAPs). Adherence to the standards will be monitored annually by the state including on-site

visits of the MCOs' administrative offices or their care delivery sites, when necessary, to assure compliance with the QAP standards.

b. The state Medicaid agency will have its own quality assurance monitoring tool against which MCOs will be measured, the goal of which will be to assure that Medicaid clients are receiving quality care, and that accreditation, reporting, and data requirements of the Department of Health are being met. The agency will report back to the MCOs the results of the review, delineating problem areas, and providing recommendations for improvement, giving a target date by which corrective actions must be taken. The state will track the progress of the MCOs to ensure adherence to the corrective actions.

c. The state Medicaid agency will also contract with an external quality review organization to conduct an independent external review of the quality of services delivered by MCOs contracting with Medicaid.

d. The state Medicaid agency will use a complaint monitoring computer program to track complaints from MCO clients as well as providers. All quality of care complaints and issues received by the division will be referred to, and monitored by a registered nurse in the Medicaid agency until resolution among all parties occurs, including the client, provider, MCO, and the BMHC.

e. The state Medicaid agency will either require MCOs, to conduct biennial consumer surveys, or the division will conducted such surveys in cooperation with the MCOs. The surveys will focus on what Medicaid MCO enrollees think of the medical care they have received. The results will be summarized in report

cards for Medicaid clients to use in deciding which MCO to select, and provided to legislators, advocacy groups, and any interested consumer.

f. The state Medicaid agency will require MCOs to report HEDIS data. The state's quality assurance monitoring team will integrate HEDIS results in the agency's future quality assurance monitoring plans. HEDIS measures will be used as performance goals; if an MCO is found deficient in an area related to a HEDIS measure, the state will include in its corrective action plan a requirement that the MCO must work to improve the measure.

g. The state Medicaid agency will track clients who change MCOs, with the reasons for change being linked to clients and MCOs. Reports will be produced that will help the division analyze trends in change between MCOs and, when necessary, the division will require corrective actions. All quality of care deficiencies will be referred to one of the quality assurance nurses in the Bureau of Managed Health Care and will be tracked until resolved.

h. The state Medicaid agency will require that MCOs maintain a system for reviewing and adjudicating complaints and grievances by enrollees. The system must permit an enrollee, or provider on behalf of an enrollee, to challenge the denials of medical care coverage, or denials of payment for covered services. If, after exhausting the MCOs' grievance processes, the clients are not satisfied with the final decisions, MCOs will inform clients that they have the right to request a formal hearing with the state. The MCOs are required to

include a copy of the state of Utah Formal Hearing Request form with the final denial notice that is sent to clients.

i. The state Medicaid agency will have a grievance system that allows MCO enrollees to request a formal hearing with the Medicaid agency if, after filing a grievance with the MCO, the client is not satisfied with the MCO's final decision.

j. The state Medicaid agency will implement a standard screening tool that will be used to determine the risk level of MCO clients (described as high, moderate or low), and will then inform the MCOs of all high-risk enrollees so that case management services can begin promptly.

7.1.02 Assuring Quality of Health Care under Fee-For-Service

The Primary Care Network (PCN) program in urban and rural counties, the Traditional Medicaid program and the PEHP-Based program in most rural areas, will be provided to eligibles on a fee-for-service basis. Either the DHCF, or the PEHP health plan administrator will have oversight responsibility for monitoring the quality of health care and utilization of services.

To assure that quality health care services are provided to clients being served under FFS, the responsible plan administrator being either the Medicaid agency, or the PEHP will:

a. identify over, and under, client utilization and patterns of aberrant provider behavior using periodic reports generated from fee-for-service claims data in areas such

as office visits, laboratory procedures, prescriptions, emergency room visits, health education, etc.;

b. conduct periodic reviews of claims files and medical audits to determine whether the appropriateness of treatment is consistent with the diagnosis;

c. use a complaint monitoring computer program to track complaints from FFS clients, as well as providers, referring all quality of care complaints and issues to a registered nurse in the Medicaid agency who will then monitor the complaint until resolution is achieved among all parties;

d. conduct biennial consumer surveys focusing on what clients served under the FFS program think of their providers and the medical care they received; and

e. have a grievance system that allows FFS clients to request a formal hearing with the Medicaid agency.

7.1.03 Medicaid Eligibility Quality Control Unit (MEQC)

The MEQC unit in the Office of the Director (DHCF) has been operating under a federal waiver from the traditional quality control function since 1996. This waiver has allowed the unit to undertake several focused pilot projects relating to eligibility, access and quality of service.

This special unit will undertake special projects focused on quality of service

under the waiver granting the state the authority to implement the PCN.

VIII. Financing

The following tables are self-explanatory

Table 8.1: Current Medicaid Population to be moved into 1115 Waiver						
Total Member Years						
Population	History Years					
	FY 1997	FY 1998	FY 1999	FY 2000	YTD: May 2001	Est. FY 2001
ash	10,718	8,595	7,667	6,032	4,689	4,902
on-Cash	3,918	5,204	4,964	4,882	7,235	7,564
ally Needy Adults (19 & Older)	697	741	608	715	473	494
xisting Population to be Merged	15,333	14,540	13,238	11,630	12,396	12,960
Total Member Months						
ash	128,620	103,144	91,999	72,389	56,269	58,827
on-Cash	47,019	62,443	59,562	58,587	86,817	90,763
ally Needy Adults	8,359	8,897	7,294	8,581	5,671	5,929
xisting Population to be Merged	183,998	174,484	158,855	139,557	148,757	155,519
Estimates for member counts was increased 4.54% to account for FY 2001 estimate						

Table 8.2: Current Medicaid1115 Waiver Expenditures						
Total Expenditures						
Population	History Years					
	FY 1997	FY 1998	FY 1999	FY 2000	YTD: May 2001	Est. FY 2001

Table 8.2: Current Medicaid1115 Waiver Expenditures

Total Expenditures

Population	History Years					
	FY 1997	FY 1998	FY 1999	FY 2000	YTD: May 2001	Est. FY 2001
ash	$40,980,000	$35,933,300	$35,165,000	$29,156,100	$25,310,500	$27,611,500
on-Cash	14,282,000	20,239,200	21,271,300	21,609,100	35,499,200	38,726,400
ally Needy Adults	2,628,200	6,094,200	4,530,700	6,715,000	4,925,400	5,373,200
	$57,890,200	$62,266,700	$59,967,000	$57,480,200	$65,735,100	$71,711,100

Disproportionate Share Hospital

ash	$176,700	$165,200	$132,600	$101,600	$90,800	$99,100
on-Cash	23,300	34,700	23,000	28,500	90,800	99,100
ally Needy Adults	41,600	94,000	80,600	83,000	51,700	56,400
	$241,600	$293,900	$236,200	$213,100	$233,300	$254,600

Expenditures Less Disproportionate Share Hospital

1931 Cash	$40,803,300	$35,768,100	$35,032,400	$29,054,500	$25,219,700	$27,512,400
1931 Non-Cash	14,258,700	20,204,500	20,248,300	21,580,600	35,408,400	38,627,300
Medically Needy Adults	2,586,600	6,000,200	4,450,100	6,632,000	4,873,700	5,316,800
Total	$57,648,600	$61,972,800	$59,730,800	$57,267,100	$65,501,800	$71,456,500

Cost per Member per Month Less Disproportionate Share Hospital

1931 Cash	$317.24	$346.78	$380.79	$401.37	$448.20	$467.69
1931 Non-Cash	303.25	323.57	339.95	368.35	407.85	``425.58
Medically Needy Adults	309.44	674.41	610.10	772.87	859.51	896.78
Total	$313.31	355.18	$376.01	$410.35	$440.33	$459.47

NOTES: Estimate for expenditure amount was increased 9.1% to account for FY 2001 estimate.

DSH amount is not to be re-allocated.

Table 8.3: Cost Estimates for Expanded 1115 Waiver Program

1931 CASH

Category	Waiver Years (Expressed as Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
Caseload Member Months	62,410	64,282	66,210	68,196	70,242
Per Member Per Month (PMPM)	$479.24	$513.03	$549.20	$587.92	$629.37
Costs with Waiver (Net of Savings)	$29,909,368	$32,978,594	$36,362,532	$40,093,792	$44,208,208
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
PMPM Savings from Reduced Benefit Package	$49.93	$53.57	$57.47	$61.66	$66.15

1931 NON-CASH

Caseload Member Months	96,290	99,179	102,154	105,219	108,376
Per Member Per Month (PMPM)	$436.11	$466.86	$499.77	$535.00	$572.72
Costs with Waiver (Net of Savings)	$41,993,032	$46,302,708	$51,053,505	$56,292,165	$62,069,103
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
PMPM Savings from Reduced Benefit Package	$45.24	$48.54	$52.09	$55.88	$59.96

MEDICALLY NEEDY ADULTS

Caseload Member Months	6,290	6,479	6,673	6,873	7,079
Per Member Per Month (PMPM)	$918.91	$983.69	$1,053.04	$1,127.28	$1,206.75
Costs with Waiver (Net of Savings)	$5,779,944	$6,373,328	$7,026,936	$7,747,795	$8,542,583
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
PMPM Savings from Reduced Benefit Package	$97.59	$104.70	$112.33	$120.52	$129.31

UMAP

Caseload Member Months	72,000	73,440	74,909	76,407	77,935
Per Member Per Month (PMPM)	$54.73	$59.90	$65.56	$71.76	$78.54

Costs with Waiver	$3,940,560	$4,399,056	$4,911,034	$5,482,966	$6,121,015
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
ADULT PARENTS UP TO 200% OF THE FEDERAL POVERTY LEVEL					
Caseload Member Months	168,000	336,000	432,600	445,678	458,945
Per Member Per Month (PMPM)	$54.73	$59.90	$65.56	$71.76	$78.54
Costs with Waiver	$9,194,640	$20,126,400	$28,361,256	$31,974,677	$36,045,540
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
TOTAL WAIVER EXPANDED COSTS					
Caseload Member Months	404,990	579,380	682,546	702,273	722,577
Per Member Per Month (PMPM)	$224.25	$190.17	$187.12	$201.62	$217.26
Costs with Waiver (Net of Savings)	$90,817,544	$110,180,086	$127,715,263	$141,591,395	$156,986,449
PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
PMPM Savings from Reduced Benefit Package	$49.01	$52.58	$56.41	$60.52	$64.93

Table 8.4: Cost Savings From Current Eligibles Moved into the Waiver

Category	Waiver Years (Expressed as Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
1931 CASH					
1Caseload Member Years	5,201	5,357	5,517	5,683	5,854
2Caseload Member Months	62,410	64,282	66,210	68,196	70,242
3Per Member Per Month (PMPM)	$479.24	$513.03	$549.20	$587.92	$629.37
4Costs	$29,909,368	$32,978,594	$36,362,532	$40,093,792	$44,208,208
5PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
6PMPM Savings from Reduced Benefit Package	$15.39	$16.51	$17.71	$19.00	$20.39
7PMPM Savings from Cost Sharing	$34.54	$37.06	$39.76	$42.66	$45.76
8Savings from Enrollment Fee (Row 2 X Row 5)	$260,250	$268,056	$276,096	$284,377	$292,909
9Savings from Reduced Benefit Package (Row 2 X Row 6)	$960,490	$1,061,296	$1,172,579	$1,295,724	$1,432,234

Table 8.4: Cost Savings From Current Eligibles Moved into the Waiver					
Category	Waiver Years (Expressed as Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
10Savings from Cost Sharing (Row 2 X Row 7)	$2,155,641	$2,382,291	$2,632,510	$2,909,241	$3,214,274
TOTAL 1931 CASH SAVINGS	$3,376,381	$3,711,643	$4,081,185	$4,489,342	$4,939,417
1931 NON-CASH					
11Caseload Member Years	8,024	8,265	8,513	8,768	9,031
12Caseload Member Months	96,290	99,179	102,154	105,219	108,376
13Per Member Per Month (PMPM)	$436.11	$466.86	$499.77	$535.00	$572.72
14Costs	$41,993,032	$46,302,708	$51,053,505	$56,292,165	$62,069,103
15PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
16PMPM Savings from Reduced Benefit Package	$13.94	$14.96	$16.05	$17.22	$18.48
17PMPM Savings from Cost Sharing	$31.30	$33.58	$36.04	$40.19	$43.12
18Savings from Enrollment Fee (Row 12 X Row 15)	$401,529	$413,576	$425,982	$438,763	$451,928
19Savings from Reduced Benefit Package (Row 12 X Row 1-6)	$1,342,283	$1,483,718	$1,639,572	$1,812,195	$2,002,789
20Savings from Cost Sharing (Row 12 X Row 17)	$3,013,877	$3,330,431	$3,681,630	$4,228,454	$4,673,175
TOTAL1931 NON-CASH SAVINGS	$4,757,689	$5,227,725	$5,747,184	$6,318,401	$6,950,152
MEDICALLY NEEDY ADULTS					
21Caseload Member Years	524	540	556	573	590
22Caseload Member Months	6,290	6,479	6,673	6,873	7,079
23Per Member Per Month (PMPM)	$918.91	$983.69	$1,053.04	$1,127.28	$1,206.75
24Costs	$5,779,944	$6,373,328	$7,026,936	$7,747,795	$8,542,583
24PMPM Savings from Enrollment Fee	$4.17	$4.17	$4.17	$4.17	$4.17
26PMPM Savings from Reduced Benefit Package	$30.08	$32.27	$34.62	$37.14	$39.85
27PMPM Savings from Cost Sharing	$67.51	$72.43	$77.71	$83.38	$89.46
28Savings from Enrollment Fees (Row 22 X Row 26)	$26,229	$27,017	$27,826	$28,660	$29,519

29Savings from Reduced Benefit Package (Row 22 X Row 27)	$189,203	$209,077	$31,019	$255,263	$282,098
30Savings from Cost Sharing (Row 22 times Row 27)	$424,638	$469,274	$518,559	$573,071	$633.287
TOTAL MEDICALLY NEEDY ADULT SAVINGS	$640,070	$705,368	$777,404	$856,994	$944,904

TOTAL 1115 PROJECT SAVINGS

31Savings from Enrollment Fees (Rows8,18, 28)	$688,008	$708,649	$729,904	$751,800	$774,356
32Savings from Reduced Benefit Package (Rows 9, 19, 29)	$2,491,976	$2,754,091	$3,043,170	$3,362,858	$3,717,120
33Savings from Cost Sharing (Rows10, 20, 30)	$5,594,156	$6,181,996	$6,832,699	$7,550,079	$8,342,9970
TOTAL 1115b PROJECT SAVINGS	$8,774,140	$9,644,736	$10,605,773	$11,664,737	$12,834,473

Table 8.5: Current Benefit Package with No Enrollment Fees or Reduced Benefits

1931 CASH

Category	Waiver Years (Expressed in Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
Caseload Member Years	5,201	5,357	5,517	5,683	5,854
Caseload Member Months	62,410	64,282	66,210	68,196	70,242
Per member Per Month (PMPM)	$533.34	$570.77	$610.84	$653.75	$699.69
Costs	$33,285,749	$36,690,237	$40,443,716	$44,583,135	$49,147,625

1931 NON-CASH

Caseload Member Years	8,024	8,265	8,513	8,768	9,031
Caseload Member Months	96,290	99,179	102,154	105,219	108,376
Per member Per Month (PMPM)	$485.52	$519.57	$556.03	$595.05	$636.85
Costs	$46,750,721	$51,530,433	$56,800,689	$62,610,566	$69,019.256

MEDICALLY NEEDY ADULTS

Caseload Member Years	524	540	556	573	590
Caseload Member Months	6,290	6,479	6,673	6,873	7,079
Per member Per Month (PMPM)	$1,020.67	$1,092.56	$1,169.54	$1,251.97	$1,340.23
Costs	$6,420,014	$7,078,696	$7,804,340	$8,604,790	$9,487,488

TOTALS

TOTALS	$86,456,484	$95,299,366	$105,048,745	$115,798,491	$127,654,369

Table 8.6: Pass Through Group: Adult Parents from 54% to 200% of Federal Poverty Limit

1931 CASH, 1931 NON-CASH, and MEDICALLY NEEDY ADULTS

Category	Waiver Years (Expressed in Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
Caseload Member Years	14,000	28,000	36,050	37,132	38,245
Caseload Member Months	168,000	336,000	432,600	445,578	458,945
Per Member Per Month (PMPM)	$54.73	$59.90	$65.56	$71.76	$78.54
Costs	$9,194,640	$20,126,400	$28,361,256	$31,974,677	$36,045,540

Table 8.7: Estimates for Baseline With and Without the Waiver

TOTAL BASELINE MEDICAID COSTS WITHOUT THE WAIVER

Category	Waiver Years (Expressed in Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
Current Eligible Program Costs	$86,456,484	$95,299,366	$105,048,745	$115,798,491	$127,654,369

Pass Through Adult Parents to 200% FPL	$9,194,640	$20,126,400	$28,361,256	$31,974,677	$36,045,540
Total Baseline Medicaid Costs Without Waiver	$95,651,124	$115,425,766	$133,410,001	$147,773,168	$163,699,909
Federal Obligation	$66,955,787	$80,798,036	$93,387,001	$103,441,218	$114,589,936

TOTAL MEDICAID PROGRAM COSTS WITH THE WAIVER

Waiver Costs for Current Eligibles	$77,682,344	$85,654,630	$94,442,973	$104,133,752	$114,819,894
Waiver Costs for UMAP Expansion	$3,940,560	$4,399,056	$4,911,034	$5,482,966	$6,121,015
Pass Through Adult Parents to 200% of FPL	$9,194,640	$20,126,400	$28,361,256	$31,974,677	$36,045,540
Total medicaid Costs Under Waiver	$90,817,544	$110,180,086	$127,715,263	$141,591,395	$156,986,449
Federal Obligation	$63,572,281	$77,126,060	$89,400,684	$99,113,977	$109,890,514

ESTIMATED INCREASES IN ADMINISTRATION

Additional Administrative Costs Under the Waiver	$3,280,000	$6,263,000	$7,146,090	$7,581,287	$8,042,987
Federal Obligation	$1,705,600	$3,256,760	$3,715,967	$3,942,269	$4,182,353

Table 8.8: Estimates for Baseline and Waiver Programs

FINANCIAL IMPACT OF WAIVER PROGRAMS

Category	Waiver Years (Expressed as Fiscal Years)				
	One: 2003	Two: 2004	Three: 2005	Four: 2006	Five: 2007
Total Savings (From Table 8.4)	$8,774,140	$9,644,736	$10,605,773	$11,664,737	$12,834,473
UMAP Costs With Waiver (From Table 8.3)	$3,940,560	$4,399,056	$4,911,034	$5,482,966	$6,121,015
Waiver Savings (Row 1 Minus Row 2)	$4,833,580	$5,245,680	$5,694,739	$6,181,771	$6,713,458
Federal FFP Savings/Additional Costs (From Row 3)	$3,383,506	$3,671,976	$3,986,317	$4,327,239	$4,699.421

IX. System Support

9.01 SUPPORT OF SYSTEMS

The DHCF will use the current Public Assistance Client Management Information System (PACMIS) eligibility system to provide the system support for eligibility functions. The division will need to make category of need modifications to support the different benefit packages and the new reporting needs for the section 1931 adult, and the expansion (PCN) populations. The division will maintain the same interfaces with the Medicaid Management Information System (MMIS), making whatever modifications necessary to support the two new groups. Claims will be paid through the MMIS as is currently done in the fee-for-service programs. New edits will be created to reflect the new benefit packages, and modifications will be made as needed in the PACMIS and the MMIS to support all required reporting. (See 10.2 and 10.3 under X. Implementation Time Frames.)

9.02 SUPPORT OF EVALUATION ACTIVITIES

The division has just recently begun installation of a new Data Warehouse system and data repository, with exceptional data and information retrieval tools. This new system gives the division reporting capabilities, such as it has never had previously, and will be used for the evaluation and reporting processes. It will give the division new tools to assist it in the formative, or process evaluation process. (See 11.1.02 and 11.2.01 under XI. Evaluation and Reporting.)

X. Implementation Time Frames

10.1 DIVISION

10.1.01 Divisional Staffing Review

The implementation of the waiver demonstration program, in addition to other program modifications underway, will not require substantial modifications to the organizational structure of the division. The director will review the divisional staffing patterns and bureau responsibilities with appropriate divisional and departmental staff to determine any changes required by the 1115 Waiver Demonstration Program; thirty (30) days.

10.1.01 DHCF Reorganization

The director will accomplish the divisional reorganization necessary to implement the 1115 Demonstration Program; thirty (30) days.

10.1.02 State Plan Review

The staff from the Bureau of Eligibility Services and the Bureau of Coverage and Reimbursement Policy will review the Medicaid State Plan for any changes required to implement the 1115 Demonstration Program; twenty-one (21) days.

10.1.03 Approval of State Plan Changes

The Regional Office of HCFA will review and approve the State Plan changes identified as necessary to implement the 1115 Demonstration Program; sixty (60) days.

10.1.04 Eligibility Changes

The Bureau of Eligibility Services will implement the eligibility changes required by the 1115 Waiver Demonstration Program between March 1 and July 1, 2002.

10.2 PACMIS

10.2.01 Assess Required PACMIS Changes

Changes in the Public Assistance Client Management Information System (PACMIS) operated by the Department of Human Services will be required to implement the waiver program. The staff from the Department of Health, Bureau of Eligibility Services, will coordinate with the staff from the Department of Workforce Services to review the necessary changes; sixty (60) days.

10.2.02 Implement PACMIS Changes

The Bureau of Management Services in the Department of Human Services will implement the required identified changes to the PACMIS; ninety (90) days.

10.3 MMIS

10.3.01 Assess Required MMIS Changes

Changes in the division's Medicaid Management Information System (MMIS) will be required to implement the waiver program. The staff from the Bureau of Eligibility Services and the Bureau of Coverage and Reimbursement Policy will coordinate the review of the required changes with the division's Information Technology Unit (ITU) to ensure

they are included in the redesign of the MMIS currently underway; sixty (60) days.

10.3.02 Implement Required MMIS Changes

The division's ITU will implement the required changes to the MMIS required by the 1115 Waiver Demonstration Program with the assistance of the Bureau of Eligibility Services; ninety (90) days.

10.4 ELIGIBILITY MANUALS

Eligibility manuals will have to be rewritten and staff training in the new requirements will be required with the implementation of the demonstration program.

10.4.01 Eligibility Manual Review

The staff from the Bureau of Eligibility Services will review eligibility manuals for changes required to implement the 1115 Demonstration Program; fourteen (14) days.

10.4.02 Rewrite of Eligibility Manuals

The staff from the Bureau of Eligibility Services will revise the eligibility manuals to incorporate the 1115 Demonstration Project; forty-five (45) days.

10.4.03 Review of New Eligibility Manuals

The Bureau of Eligibility Services will circulate for review and comment the new versions of the eligibility manuals; fourteen (14) days.

10.4.04 Final Eligibility Manuals

The Bureau of Eligibility Services will make any appropriate changes developed from the manual reviews and write the final manual versions; seven (7) days.

10.4.05 New Eligibility Manual Implementation

The Bureau of Eligibility Services will implement the changes required by the 1115 Demonstration Program between March 1 and July 1, 2002.

10.5 PROVIDER MANUALS

Provider manuals will have to be rewritten and provider training in the new benefit packages will be required with the implementation of the demonstration program.

10.5.01 Provider Manual Review

The staff from the Bureau of Coverage and Reimbursement Policy will review provider manuals for changes required to implement the 1115 Demonstration Program; fourteen (14) days.

10.5.02 Rewrite of Provider Manuals

The staff from the Bureau of Coverage and Reimbursement Policy will review and revise provider manuals to incorporate the 1115 Demonstration Project; forty-five (45) days.

10.5.03 Review of New Provider Manuals

The Bureau of Coverage and Reimbursement Policy will circulate for review and comment the required changes; fourteen (14) days.

10.5.04 Final Provider Manuals

The Bureau of Coverage and Reimbursement Policy will make any appropriate changes developed from the manual reviews and write the final manual versions; seven (7) days.

10.5.05 New Provider Manual Implementation

The Bureau of Coverage and Reimbursement Policy will implement the changes required by the 1115 Demonstration Program between March 1 and July 1, 2002.

10.6 RULE MAKING

Modification in the state rules will be required to implement the new program. The staff from the Bureau of Coverage and Reimbursement Policy will begin the state parallel rule-making process.

10.6.01 State Rule Writing

The staff from the Bureau of Eligibility Services and the Bureau of Coverage and Reimbursement Policy will write the state rules necessary to implement the new program; fifteen (15) days.

10.6.02 Departmental Approval of the Rules

Legal staff from the Department will review and approve the requested rule changes for the signature of the Executive Director of the Department of Health; fourteen (14) days.

10.6.03 Rule Publication

The Bureau of Eligibility Services will submit the new state rules for

publication; five (5) days.

10.6.04 Public Comment on New Rules

The public has sixty (60) days in which to comment on the proposed new state rules to implement the 1115 Waiver Demonstration Program.

10.6.05 Public Hearings

The Office of the Director, DHCF, will schedule and hold public hearings, if required, on the proposed state rule changes.

10.6.06 Amendments to Proposed State Rules

The Bureau of Eligibility Services, coordinating with the Bureau of Coverage and Reimbursement Policy, will make any amendments to the proposed state rules if made necessary by public comment or public hearings. The amendments will be reviewed and approved by the legal staff and Executive Director of the department; thirty (30) days.

10.6.07 Republishing State Rule Changes

The Bureau of Coverage and Reimbursement Policy will republish the proposed state rule changes after amendments to them have been made as a result of the public comment and hearings; fifteen (15) days.

10.6.08 Public Comment on Amended Proposed State Rules

The public has a thirty (30) day period in which to make any comments on the amended proposed state rules.

10.6.09 State Rule Adoption

The proposed rules necessary to implement the 1115 Waiver Demonstration Program must be adopted between February 28 and June 30, 2002 (one day prior to the effective date).

10.7 PARALLEL NOTICE DEVELOPMENT

There are currently approximately 17,000 uncovered, uninsured adults of children enrolled in Medicaid where the family net income is under 100% of the FPL. There are also adults without children enrolled in Medicaid who will need information on the new program. Those whose benefits will be reduced or will realize increased cost sharing will receive adequate advance notice of the change.

10.7.01 Notice Development

The staff from the Bureau of Eligibility Services will develop client specific notices to 1931 and medically needy recipients explaining the change in benefits and co-payments to be mailed 30 days prior to effective date; fifteen (15) days.

10.7.02 Client Newsletter

The staff from the Bureau of Eligibility Services, working with the department's Chief Information Officer, will develop an article for the client newsletter explaining all applicable changes to the program to be mailed 60 days prior to implementation; thirty (30) days.

10.7.03 Public Notice

The staff from the Bureau of Eligibility Services, coordinating with the department's Chief Information Officer, will develop a public notice of the expansion of eligibility and program description which will be distributed throughout the community beginning 60 days prior to implementation; thirty (30) days.

10.7.04 Provider Notice

The staff from the Bureau of Coverage and Reimbursement Policy, coordinating with the Bureau of Medicaid Operations and other division staff, will develop a notice to all providers explaining the 1115 demonstration and providing a detailed explanation of the changes in coverage; thirty (30) days.

10.8 TRAINING

10.8.01 Review and Develop Staff Training

The staff from the Bureau of Eligibility Services will review the required changes in the State Plan, new state rules, PACMIS and MMIS, and develop training plans, preparations, schedules and training packets; thirty (30) days.

10.8.02 Provide Staff Training

The staff from the Bureau of Eligibility Services will train all appropriate divisional staff in the new 1115 Demonstration Program requirements and changes in operations; sixty (30) days.

10.8.03 Review and Develop Provider Training

The staff from the Bureau of Coverage and Reimbursement Policy will review the required changes in the State Plan, new state rules, and provider manuals, and develop training plans, preparations, schedules and training packets; thirty (30) days.

10.8.04 Provide Provider Training

The staff from the Bureau of Coverage and Reimbursement Policy and the Bureau of Medicaid Operations will train providers in the new 1115 Demonstration Program requirements and changes in operations; sixty (30) days.

10.9 DATA MANAGEMENT

10.9.01 Data Collection

The staff from the Office of the Director will coordinate the collection of data throughout the life of the waiver demonstration program.

10.9.02 Data Analysis

The staff from the Office of the Director will coordinate the analysis of the data collected throughout the life of the waiver demonstration program and forward recommendations to the Director of the Division of Health Care Financing.

10.9.03 Federal Reporting

Reporting to CMS on the progress of the 1115 Waiver Demonstration Program will begin during Project Year One and continue throughout the life of the program.

XI. Evaluation and Reporting

11.1 EVALUATION

Program evaluation is useful not only in assessing the outcomes of a project or program being evaluated, but also necessary for finding ways of improving the program. The DHCF is vitally interested in the evaluation process and its outcomes, as it believes that the information derived will immensely benefit the state's continuing efforts in health care reform. It will also provide information useful to other states as they embark upon health care reform.

11.1.01 Summative Evaluation

As with all 1115 waivers, it is presumed that CMS will arrange for an independent contractor to conduct the summative evaluation. The summative evaluation will allow an informed judgement as to the overall success of the PCN and its objectives. In other words::

a. Did the demonstration successfully achieve the desired impact?

b. If not, why?

11.1.02 Formative Evaluation

Formative evaluation data, on the other hand, will be crucial for the overall structure and implementation of the PCN. Because of the complexity of the project and the fact that the extent of the program being delivered cannot be assumed, the summative—or impact evaluation—will not provide the level of confidence that the policy makers of the state will require to continue the program, without a structured formative evaluation process.. The DHCF will conduct a formative evaluation throughout the duration of the demonstration. This information will help to structure, guide and successfully implement the project.

a. While there are differing definitions of *formative evaluation* in the literature, the division will define it as *process evaluation*, and may

use the terms interchangeably.

b. The division will collect and use empirical data to ascertain if the delivery of the program is meeting its objectives. In other words, to verify:

1) what the program is that is being delivered;

2) is it being delivered to the targeted audience as intended; and

3) are the benefits and services being delivered those that were intended.

c. Since evaluation in this context will not require precise causal inferences necessitating comparative design, the state can develop such information through the data collection on appropriate process measures, and the state will be able to:

1) obtain feedback on the quality of the ongoing delivery of the benefits under the PCN. In this way, the state can insure the highest degree of congruence between intention and delivery;

2) determine who is receiving the benefits and services of the PCN to insure that the program is reaching the intended recipients; and

3) determine to what degree recipients in different regions of the state are receiving the benefits.

4) The evaluation process will be overseen by the Research and Evaluation Unit located in the Office of the Director, DHCF.

11.1.03 Project Evaluability

An *evaluability assessment* will be conducted within the first 60 days of the

PCN implementation involving policy makers, program managers, and staff; in other words, all users of the evaluation information. Such an assessment will assist the state in:

a. elucidating the intended program from the viewpoints of all the stakeholders;

b. define and lock-in the plausibility of the program goals and objectives, and determine their measurability;

c. define the data elements necessary to measure the progress of the program;

d. come to agreement on required changes in any program objectives, or services and benefits;

e. define the final evaluation design;

f. define evaluation priorities;

g. define the intended uses of the evaluation data;

h. define the expected accomplishments by structured time periods; and

i. develop the reporting periods and format, including the structure, how data obtained will be presented, the use of tables, graphics, figures, etc..

The division will conduct an *evaluability assessment* annually to ensure that the formative evaluation remains consistent with, and descriptive of the program purpose.

11.2 REPORTING

11.2.01 Periodic Reporting

The division will produce periodic internal reports throughout the duration of the waiver that will:

a. provide the observed results of the program to date and during the reporting period;

b. estimate future targets or desired results by specified time periods;

c. define any problems experienced during the reporting period;

d. set solutions to correct identified problems;

11.2.02 Annual Reports

The division will provide an annual report to the CMS detailing the progress of the waiver project.

a. interim problems encountered.

b. interim solutions effected.

11.2.03 Final Report

The division will write and provide to CMS a final report at the end of the waiver project that will describe:

a. the project successes

b. the problems encountered

c. the solutions implemented to solve any encountered problems, and

d. any necessary program changes made during the course of the

project.

XII. Waivers Requested

The state requests FFP for expenses not otherwise matched under Section 1903 of the Act. Additionally, in order for the state of Utah to implement the proposed demonstration project described in previous sections of this document, it must receive waivers of several statutory and regulatory requirements. The waivers requested are set out below.

12.1 AMOUNT, DURATION AND SCOPE OF SERVICES

Section 1902(a)(10)(B) and 42 CFS § 440.230-250 require that the amount, duration, and scope of services be equally available to all recipients within an eligibility category, and also be equally available to categorically eligible recipients and medically needy recipients. Utah's demonstration project will be based on having three different benefit packages that cover different eligible populations.

12.2 PROVISION OF SERVICES

Sections 1902(a) and 1905(a) require that specific services listed in 1905(a) be provided. Utah requests a waiver of this provision to allow a reduced benefit package to be provided to expansion PCN eligibles and the TANF related adults identified in Section 1902(a).

12.3 INCOME LIMITATIONS

Sections 1902(1), 1903(f), and 42 CFR § 435.100 *et seq.* prohibit payment under Medicaid to states which implement income eligibility standards in excess of the maximums allowed by regulations. Utah requests a waiver to expand eligibility to individuals with incomes which exceed those levels.

12.4 ELIGIBILITY STANDARDS

Section 1902(a)(10)(B) requires income methodologies to be no more restrictive than the methodologies employed under the most closely related cash assistance program. The state of Utah requests a waiver of these requirements because some of the financial methodologies being proposed are more restrictive. Section 1902(a)(17)(D) restricts taking into account the income of anyone other than the individual, the individual's spouse or the individual's parent. Utah requests a waiver of this requirement because it intends to count all family members' income in the eligibility process for the expansion PCN enrollees.

12.5 RETROACTIVE ELIGIBILITY

Section 1902(a)(34) and 42 CFR § 435.914 require states to retroactively provide medical assistance for up to three months prior to the date that an application for such assistance is made. Utah requests a waiver of these requirements because it will not provide retroactive eligibility to the expansion PCN population.

12.6 PAYMENT TO FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS

Section 1902(a)(1) requires that payment to a Federally Qualified Health Center (FQHC) must be in accordance with the prospective payment system set forth by that Section. The state requests a waiver of § 1902(a)(1) for the PCN expansion enrollees only.

12.7 CO-PAYMENT REQUIREMENTS

The state requests a waiver of Section 1902(1)(14) and CFR § 447.54 and 447.53 because it will require co-payments in excess of the maximum amounts from the expansion PCN population.

12.8 CATEGORIES OF ASSISTANCE

Section 1902(1)(10) describes individuals to whom the state can provide medical assistance. The state needs a waiver of 1902(1)(10) because it will provide medical assistance to individuals not described in the Act.

12.9 COMPARABILITY

Section 1902(a)(17)(A) requires standards to be comparable for all groups. Utah requests a waiver of this requirement to exempt pregnant women in the high risk category from the resource limit. (See the state's earlier independent submission of this request for details.)

The state requests any other waivers CMS deems necessary for approval of this demonstration.

s t a t e

Attachment A:

Organizational Charts

Utah Department of Health
Division of Health Care Financing
November 15, 2001